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LIVING WITH A HISTORY OF A HEART ATTACK: A HUMAN SCIENCE INVESTIGATION

BY

© JOAN S. FORD

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Joan S. Ford
(Student's signature)

#2109- 8210- 111 STREET
(Student's permanent address)
EDMONTON ALBERTA T6G 2C7

Date: December 8, 1986

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled LIVING WITH A HISTORY OF A HEART ATTACK: A HUMAN SCIENCE INVESTIGATION submitted by JOAN S. FORD in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Secondary Education.

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(Supervisor)

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External Examiner

Date October 28, 1986

To my mother, Ruby Forde,

for her enduring support.

ABSTRACT

The intent of this study is to gain insight into and a deeper understanding of living with a history of a heart attack for males at least two years after the event. A heart attack is a sudden, dramatic and sometimes fatal event; we suspect that it is a profound experience which affects the very core of the individual's being. But how is the heart attack and particularly life after the event experienced? What is it like to live with a history of a myocardial infarction (heart attack)?

In order to address this question, I used a human science approach which aims, through description and interpretation, to illuminate the participants' experiences and to reveal their meaning. The descriptive interpretive work of the study is based on conversations with seven men who had heart attacks and all of whom subsequently returned to work. Each person begins his story with the event and progresses through time to the present.

The stories of the seven interviewees are presented in the form of re-constructed narratives. In each person's story we can detect a certain pattern of meaning, a thematic concern. These same patterns were shared to some extent among the various narratives; but they did not occupy, in the same manner, centre stage.

The inquiry, however, moves beyond the individual since the quest is to identify and explicate aspects of life after a heart attack which are possible shared human experiences. These possible human experiences I refer to as "the experiential characteristics" which emerge

from descriptions focusing respectively on corporeality, sociality, temporality, and spatiality. The experiential characteristics reveal that the body emerges as a separately experienced entity as it impedes choices and action; that the other has the potential for assisting the post-MI patient to re-engage his world or for distancing him from it; that the past lives in the present; that to live authentically the post-MI patient has to create a world where he can feel secure and in control.

Finally, this inquiry raises the question of how to access the individual's experience, a question which is focal to nursing practice.

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J.S.F.

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CHAPTER 1

THE WAY TO THE QUESTION

Introduction

> His breath was coming hard. He felt faint. He was sweating. . . . A powerful burning sensation was beginning to spread through his chest, radiating upward into his throat. . . . the pain was growing worse. Now it was crushing--"crushing" just as it is always described. And worse even than the pain was the sensation of losing all power, a terrifying seepage of strength . . . . He felt he was about to die . . . . "I'll be damned," he thought, "I can't believe it." (Lear, 1980, pp. 3,4)

> Questions raced through my mind faster than I could formulate them on my lips: Would I die? Could I work again? Could I play tennis? Could I make love? Or would it be a rocking chair and a lifetime subscription to Playboy? . . . I am only 38 years old! How the hell could I have a heart attack? (Halberstam and Lesher, 1978, pp. 9,41)

> Well, I tell you. I always considered myself to be in pretty good condition. So it took me by surprise when I learned that it was my heart. When the doctor told me it was, I asked him if I could play ball again. I asked him if I could do normal things. (Viswanathan and Visner, 1984, p. 84)

In Canada, heart and blood vessel disease is the leading cause of death, with myocardial infarction (heart attack, or MI for short) deaths being the largest single killer (Facts and Figures, 1985). It often strikes quickly and unexpectedly; the cause and the outcome is never certain. One minute the person is in complete control, and the next minute he may be fighting for his life. With the realization that

he has had a heart attack there is often disbelief and then a wondering about how this event will change his life. A heart attack overwhelms and transforms. Life is never the same as it was before. How does a heart attack change a person's life? What can he expect from life? There is always the possibility of another, perhaps fatal, attack. How is it for the individual to live with this? What is it like to live with a history of a heart attack?

The purpose of this inquiry is to gain insight into and a deeper understanding of the experience of living with a history of a heart attack for males at least two years after the event. I selected males because the incidence of MI is greater in males than females to age 65 (Statistics Canada, 1983, pp. 40, 41). One cannot assume, however, that the woman's experience of an MI is similar to the man's experience. A heart attack often strikes a man in the prime of his life. He is often a husband and a parent. In his roles as husband and father he may be the sole breadwinner. Even if he is not, his salary is usually a major source of income for the family and it is needed to maintain the family's standard of living. If he is a blue-collar worker, he may have to change his occupation to a less taxing one; hence, he loses his seniority and security in the work force. For this individual, finding employment is difficult for three reasons: (1) because of his age, (2) because he may require re-training, and (3) because of his heart attack, he is seen as a risk. From the financial perspective this could be a major catastrophe not only for the individual but for the family unit. Moreover, psychosocial stressors have brought some marriages to the breaking point (Mayou, Foster and Williamson, 1978).

I chose to study individuals at least two years after the experience for two reasons:

1) The majority of studies cited in this inquiry report follow-up which was done within the first year of the event, many of these within the first few weeks. There are very few reports on subjects up to two years after the event.

2) If this study were to focus on the period immediately following the MI, it would be difficult to separate the question of the nature of life after a heart attack from the illness and the convalescent experience itself. That which endures over the long term is more likely to speak to the fundamental problem of this study.

This inquiry seeks through description and interpretation to illuminate the participants' experiences and to reveal their meaning. Thus my orientation to the inquiry focuses on the lifeworld--that is, the human experience as it is lived. More specifically, it emphasizes the individual's awareness of himself, others and his surroundings. My inquiry, however, moves beyond the individual, since my quest is to identify and explicate the experiences which are shared by the participants. These shared experiences I refer to as the common experiential characteristics which emerge from the descriptions of lived body, being with others, lived time and lived space.

Since this study is about males who have had a heart attack, the masculine gender is used throughout.

My Interest in the Study

A question, Gadamer (1960/1984) says "opens up as it were, the being of the object" (p. 326). But the question is based on certain presuppositions, so at the same time that it opens up it limits, because the question is asked from a particular perspective rather than another. Hence, "the asking of it implies openness but also limitations" (p. 327). So it behooves the person who seeks to be cognizant of that which animates the question, and how the very asking of the question may truly open or fail to do so. This, as Burch[1] pointed out, "puts one in the paradoxical position of having to know what the subject matter would be like 'truly opened' in order to know that one's question is appropriate; and of needing appropriate questioning to open the subject matter truly." With this in mind, I shall give an overview of my experiences with cardiac patients--in which this study is rooted--so as to share with the reader my perspective of the question.

In 1977, I requested and was granted a five-month leave of absence from my teaching position at a University Faculty of Nursing to pursue my interest in the nursing care of cardiac patients. I enrolled in a post-graduate programme in Cardiovascular/Intensive Care Nursing. The programme's focus was on the nursing care of acute myocardial infarction patients. My interest, however, was in the post-hospital stage, the convalescent stage. Nevertheless, I believed that it was important for me to know about the patients' hospital experiences and to become

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[1] R. Burch (personal communication, August 20, 1986)

familiar with the treatment modalities. I did have the opportunity, however, to explore the rehabilitation programme that the hospital offered to its in-patients and to talk with people from other disciplines, such as a dietician and a social worker, who had some contact with these patients. There was only one out-patient cardiac rehabilitation programme in the city at that time and the major emphasis was on exercise.

After completing the programme, I obtained permission from the hospital to spend half a day each week in the coronary care unit (CCU) and the post-CCU unit. I wanted this experience so as to keep up-to-date with the treatment of myocardial infarction patients. I was also involved with the nurses in developing their nursing care plans, and I assumed responsibility for a one-hour class on cardiac rehabilitation for the patients on the unit. During my weekly visits to these two areas I often had conversations with the patients. One particular episode remains with me. After one of the patient teaching sessions, a patient approached me and began to talk about his heart attack. This was his second one. After his first one, he had been so depressed that one day he went out, ostensibly to jog, his intent was to push himself to the limit; his aim was to precipitate a fatal heart attack. He reckoned this would be a more acceptable way of committing suicide; it would seem like an accident. From time to time, we read in the press about persons who die of heart attacks while jogging: who would suspect this man's motive? He did not achieve his goal. He said, "My legs gave out before my heart did."

In 1979, I was a Sabbatical Fellow at The W. K. Kellogg Centre for

Advanced Studies in Primary Care. This experience provided me with the opportunity to develop additional clinical skills. I had a practicum in a Family Practice Unit. There the nurses were involved in health teaching and doing health assessments. The experience which I had in that unit proved invaluable to me when, on my return to the University, I was assigned to teach a clinical course in nursing cardiac patients.

Following my return to the University, one of my colleagues who knew of my interest in cardiac rehabilitation invited me to work with her to develop a Cardiac Rehabilitation Programme for an out-patient clinic. The medical director of the programme was interested in a more comprehensive approach to cardiac rehabilitation and he felt that nursing could make a contribution.

At that time, we were working with the Orem Self-Care Nursing Framework (Orem, 1980), and we decided to use this framework as a guide to developing the programme. The concept of self-care seemed most appropriate in an out-patient programme as it acknowledged the patient as a responsible and active partner in the provision of care. It allowed for reflection and exploration of the individual's unique situation (Gulino, 1982). In the actual delivery of care, however, the individual's unique situation was often overlooked; and as I became more aware of this omission, the focus for my research study surfaced.

We developed and implemented the programme. Admittedly, it was short-lived due to a number of circumstances over which we had no control. I had the opportunity, however, to use the framework for five weeks with cardiac patients at the clinic; and I believed that it had possibilities. Due to lack of time, I severed my connection with the

clinic in 1983 when I enrolled in the Ph.D. programme. In the last six months of my association with the clinic, I was more involved in the exercise programme than in the nursing programme. This involvement broadened my awareness and understanding of another dimension of the post-MI patient's experience.

Why did I choose to study the experiences of persons who live with a history of a myocardial infarction? In part it was due to my experience with the cardiac rehabilitation programme, in part to a growing awareness of the need to understand the lived experience of the post-MI patient if he is indeed to become an active partner in care. During the period that I was involved with the cardiac rehabilitation programme, I began to wonder why it was that some people complied with the treatment regimen in the short term, but failed to do so over the long term. More specifically, what was meant by cardiac rehabilitation of post-myocardial infarction patients from the patient's point of view? Did it mean that the patient merely complied with the therapeutic regimen, that is, he substituted "healthy" behaviours for "unhealthy" ones--or is it more than that? How did the patient re-orient to himself, to others, and to his surroundings?

For these questions to be meaningful to health care professionals, we must first determine what it is like to be a person with a heart condition. These insights then should become the ground for the cardiac rehabilitation programme, instead of the present orientation which is to the disease process--the pathophysiology and the treatment modalities. Cardiac rehabilitation is understood as a technical problem; consequently, there is a search for technical solutions, and the

grounding is technical rather than experiential.

The technical approach encourages objectification of the individual and fosters a dependent rather than a therapeutic alliance. The programme is developed and implemented by the health care professionals. The post-MI patient may passively undergo the regimen, and this can be self-alienating. Marcel (1964) describes the personal alienation that surfaces in this superior-subordinate relationship:

> The individual who tries to coerce us, forgets or pretends to forget, that we are men; in so far as we give in to him, we cease to be present to ourselves, for he alienates us from ourselves; it might be said that he puts us in a state of somnambulism. (p. 51)

Compliance may mean blindly following the presented plan and may negate any attempt on the individual's part to explore the meaning of the experience for himself. Thus, over the long term, he may be unable to assume responsibility for his own care. Moreover, the cardiac rehabilitation programme may focus on only one component; for example, it may stress exercise. In this technical approach there is an inherent danger of viewing the individual not as a whole person but as an assembly of parts.

On the one hand, I am aware of the need for health care professionals to develop cardiac rehabilitation programmes so as to minimize the post-MI patient's risk factors. As Kannel (1979) states:

> Patients and their families require education about their cardiac disease and its management so that they can assume some responsibility for their care, overcome feelings of helplessness, increase confidence and be reassured about their health, family role, recreation and job capabilities. (pp. 11, 12)

On the other hand, in spite of these laudable educational goals, why do

some patients fail to comply with the treatment regimen? Is it because the health care professionals fail to relate to the post-MI patient as an individual, to understand his lived experience which gives meaning and significance to the rehabilitation programme? As I struggled with these questions and others, I came to realize that the problems of living with a history of a heart attack are far more complex and far less understood than I had anticipated. Thus it is with an eye on the lived experience that my quest for understanding and insight begins--the lived experience being the pre-reflective experience, that which is personally encountered, undergone, or lived through.

CHAPTER 2

WHAT DO WE KNOW ABOUT LIVING WITH A HEART ATTACK?

Introduction

There are two sources which may provide insights of a certain type about the question of what life is like after a heart attack. One source is the body of research studies; the other source is the body of biographical and autobiographical literature. The former is largely based on traditional scientific approaches. This orientation, as Omery (1983) aptly states, "reduces the human being under study to an object with many small quantitative units.... It gives no clues as to how to fit these small units back into the dynamic whole that is the living human body" (p. 49). The latter source which usually takes the form of stories is largely oriented to making the experience accessible and focuses on the uniqueness of the individual; it has a holistic quality to it.

Relevant Research Studies

The research studies which are most relevant to my inquiry are those which deal with coronary-prone behaviour patterns, seeking medical assistance, and the psychosocial aspects of recovery and illness.

These studies relate to the individual's lifeworld; however, they fail to elucidate experiential aspects of this lifeworld.

The Coronary-Prone Behaviour Pattern

Are some persons more likely to suffer a myocardial infarction because of personal traits which influence the way they act and react to others, time, and space? Observant clinicians throughout the decades have noted that people with coronary disease differ from those who are unaffected (Jenkins, 1979); they tend to exhibit characteristic personality and behavioural traits. Friedman and Rosenman (1974), two cardiologists who for over 30 years have studied coronary heart disease, have described a complex of emotional reactions which they believe is a risk factor. They have designated the behaviour pattern as Type A. According to Jenkins (1979), Friedman defines the coronary-prone behaviour pattern as:

> a characteristic action-emotion complex which is exhibited by those individuals who are engaged in a relatively chronic struggle to obtain an unlimited number of poorly defined things from the environment in the shortest period of time in this same environment. (p. 6)

The behaviour surfaces in any situation where there is an element of challenge; the individual perceives the situation as important and is in some way challenged or frustrated by it.

Jenkins reviewed studies of different aspects of the coronary-prone behaviour pattern. These studies were done by researchers with many different theoretical backgrounds and in different countries. From his review, Jenkins found that the overt behavioural characteris-

tics could be assigned to seven categories: values, style of thought, interpersonal relationships, style of response, gestures and movements, facial expressions, and rhythm of breathing. Not one Type A individual demonstrated all the characteristics of each category.

Jenkins notes that the "seven categories of signs and symptoms of the Type A behaviour pattern relate primarily to observable features of the type of response" (p. 20). He cautions that one must take into account the content of the statements.

> Specific kinds of content indicative of the coronary-prone behaviour pattern include indications that one is "always on the go," is exceptionally competitive, has high ambitions, demands high achievement of oneself, has a past history of promotion and recognition, has a past history of leadership in competitive situations, is always prompt, is always in a hurry (even when it is not necessary), is impatient and cannot stand to wait, is deeply committed to job or profession to the neglect of other aspects of life, is serious and precise about performance in all settings. (p. 20)

The coronary-prone behaviour pattern appears to be predictive of different clinical subtypes of coronary diseases--that is, acute myocardial infarction, silent myocardial infarction, and angina pectoris without an infarction. Jenkins cites three studies which revealed that "future candidates for all three manifestations of coronary disease had different subsets of Type A characteristics" (p. 25). Men who developed acute myocardial infarction were "serious, competitive, and concerned about time but reported much restraint in expressing these behaviours, particularly when it would make them socially conspicuous" (p. 25).

Gentry, Baider, Oude-Weme, Musch and Gary (1983) studied the differences between Type A and Type B patients' responses to acute myocar-

dial infarction (AMI). They found that Type A individuals were characterized by time urgency, preoccupation with work and hostile/competitive interpersonal relationships. Type B individuals "were more relaxed and easy going" (p. 212). In addition, Type A patients were more likely to use the defense mechanism of denial to cope with "the life-threatening realities of AMI" (p. 212), were anxious and depressed during the recovery period, and expressed heightened concerns about death. Type A patients, however, had a significantly shorter hospitalization.

Gentry et al. further investigated the relationship between Type A/B behaviour patterns and length of hospitalization. They found:

> Type As to be more alert, more active, friendlier, more competitive, more emotionally withdrawn, and more concerned about return to work than Type Bs while hospitalized. (p. 213)

Type As, also, took more initiative for their daily hospital care; hence, they were discharged sooner.

It would seem that the illness is perceived as a challenge to be overcome so Type As respond by "taking charge." In the long run this response seems to be detrimental, as they are "more prone toward recurrent and fatal AMI" (p. 213).

There is convincing research evidence which implicates Type A behaviour as a risk factor in coronary artery disease. For those who develop a myocardial infarction, continuing to engage in this kind of behaviour could be fatal. As noted earlier, challenging and frustrating situations trigger this behaviour. It would be advantageous for the patient to change his response. In the short-term this may be possible, but is it in the long-term? What is it like for the patient

to change a life-long way of responding? How does the patient's life-world facilitate or hinder what may be genuine attempts to change?

The study of Gentry et al. raises the question of whether it is possible to alter Type A behavioural responses. The behaviour is diagnosed by structured interviews and questionnaires, but the cause is unknown.

So far, studies which have attempted to modify the undesirable behaviour have been unsuccessful. But Friedman et al. (1982) believe that behaviour modification is feasible. They are conducting a five-year study of 1035 post-MI patients. Their subjects are assigned to three groups. Three hundred individuals receive counselling, in small groups, on coronary risk factors; six hundred receive counselling on risk factors and on the ways to reduce the intensity of their Type A behaviour. The remaining subjects do not receive either cardiologic or behavioural counselling and serve as the control group. The preliminary findings at the end of the first year of the study show that the rates of infarction and cardiovascular death are significantly lower in the second group. The rate of nonfatal infarction is also lower among subjects in this group than among the first group or the dropouts of their groups. These findings are not surprising because in many ways the risk factors are related to the personality type, so any modification in the Type A behaviour pattern should facilitate changes in the risk factor behaviour. For example, if a patient is told he must avoid stressful situations, without behavioural counselling to facilitate a change in attitude, it is most unlikely that he will succeed.

These researchers are also investigating the circumstances which

most often precede re-infarction or cardiovascular death. These are:

> (1) emotional stress--the sources are from quarrels with business associates, competitors or family members; exhaustion from participating in too many events, watching televised sports in which the participants . . . become overstimulated and excited, and frustrations enduring days or weeks;
>
> (2) excessive physical activity;
>
> (3) ingestion of "a single fatty meal containing more than 60g of animal or vegetable fat may induce postprandial sludging of erythrocytes." (p. 91)

The Heart Attack

Both Levy (1981) and Cowie (1976) studied MI patients' responses to the experience of the heart attack. When patients were asked to describe what brought them into the hospital, they located the event within the space and time of their everyday world of concerns. For example, "Last Tuesday after lunch. . . . There's this apartment house . . . and we're putting on a new roof. I got out of the car and started toward the house" (Levy, p. 159). Levy also reported that the overall process of undergoing a heart attack is experienced "as an extraordinary loss of vital energy" (p. 158). This corroborates the findings of other studies.

Both Levy and Cowie found that at first the patients attempted to normalize the symptoms in a variety of ways; for example, they regarded them as indigestion or the recurrence of another problem for which treatment in the past proved successful. Depending upon their self-diagnosis, they treated themselves accordingly; the treatment for indi-

gestion was an antacid. They continued, or at least tried, to do what they were doing at the time of the onset of the symptoms. As the pain and the other symptoms--breathlessness and sweating--became more severe, they summoned help. Another was called upon "to intervene as the individual gradually or suddenly loses energy as an independent agent" (Levy, p. 163). This helplessness and this loss of control was most difficult for some individuals.

Unlike Levy, Cowie found that most patients during their hospitalization tried to make sense of their heart attacks. These events were seen to have causal antecedents and were not sudden unanticipated incidents. They reconstructed their pasts to normalize their heart attacks. This may have implications as to how the patient copes in the future, which is suggested by Levy's findings.

Levy found that those individuals who were able to make sense out of their heart attacks did so by relating their pasts to the present. For example, "Things I used to do . . . getting out and mowing the yard in the heat . . . that was part of it. My job . . . I worked pretty hard unloading coal . . . in all kinds of weather . . . for twelve years. I wore myself out" (p. 169). Those who successfully reconstructed their biographies were clear about future motives and intentions to cope with their situations; those who failed were vague about coping in the future.

Levy wonders if one impediment to reconstructing is social isolation. The patients in her study were in single rooms, whilst Cowie's were in an open ward where they interacted with each other. But even in Cowie's study, all of his subjects did not successfully reconstruct

their pasts. Could it be that some people require more time and this may not happen until the post-hospital period? What if it never happens? Are they the non-compliers with the therapeutic plan? How do they maintain this masquerade?

Psychological Aspects of Recovery

Doehrman (1977) reviewed the literature (from 1968 to 1977) pertinent to the psychological aspects of recovery from a heart attack. He found that patients experience intense emotional reactions to their illnesses which eventually subside after a period of months. They fear recurrence and possible death from a second MI. The loss of self-esteem results in depression and a "reorganization in the sense of self that is generally accomplished within a year" (p. 202). It is not uncommon for them to experience diminished libido and impotence--probably because of the fear of dying during intercourse--and of decreased self-regard. The patients' diet, medication, and physical activity are sources of conflict between the patients and family members. The patients resent the over-protectiveness and concern which their spouses and family show; "they attempt to dominate others when they return home" (p. 202). The most stressful period for the MI patient is probably four months after the event when "no longer sick yet not completely recovered, the patient begins the difficult process of returning to work" (p. 203). Is this the time when re-infarction is most likely to occur?

The foregoing findings were based on publications which Doehrman

labelled clinical reports and were derived from non-directive interviews. In the following paragraphs the findings of the empirical category are summarized. The empirical reports are based on "objective data" concerning social and psychological variables such as social class, employment opportunities, anxiety, and depression.

It is estimated that over fifty percent of all deaths following an MI occur within the first four hours (p. 202): hence, delays in arrival at the hospital are hazardous to the patient. Patients with a history of angina, or a previous MI, or who self-medicated, or who contacted their doctor, delayed going to the hospital. Social and psychological factors were not generally or systematically found to be related to the time delay. This finding is probably due to the nature of the research question asked, or the failure to go beyond the responses, in the way that I have attempted below, to look for the deeper meaning structure.

The in-hospital studies revealed that most patients seemed to feel secure in the Coronary Care Unit; both the ECG monitor and the nurses were important, reassuring features. A more recent study corroborates this finding (Ameida and Wegner, 1980). Doehrman, however, feels that there are scientific shortcomings in some of these studies. As far as the pyschological dimension is concerned, there is evidence that a substantial number of MI's are emotionally upset the predominant symptoms being anxiety within the first two days and then depression. While some patients use the mental mechanism of denial, there is some evidence that the deniers may be less anxious than the non-deniers.

There is a higher incidence of post-hospital emotional distress. The anxiety and depression may last for months and sometimes years. In

addition, Doehrman cites a paper by Rahe and Paasikivi that reported "MI patients undergo more life changes within one year on either side of their illness than 1-3 years after the illness" (p. 206).

Approximately seventy-five percent (75%) of previously-employed MI patients return to work within six months, with about eighty-five percent (85%) returning by twelve months. It is estimated that twenty percent (20%) of those who return either change jobs or reduce their hours. Delays in returning to work were more often psychological in origin than medical.

The data from two research studies suggest that there is a decrease in the level of sexual activity post-MI because of "psychological and interpersonal concerns, rather than due to physical consequences of the illness" (p. 214).

A minority of MI patients suffer persistent pyschosocial handicaps greater than would be expected by their cardiac state (Mayou, 1984). Mayou wished to know if it was possible to identify those at risk. One of his concerns was to determine whether the long-term outcome could be predicted more accurately in early convalescence than during the hospital stay. He also wished to know whether psychological and psychosocial outcomes were related to cardiological variables. Data from two prospectively studied series of (n = 129 and 100) MI patients revealed that the prediction of emotional and social outcomes was much better if a further assessment was made early in convalescence. With regard to the cardiological variables, patients who suffered cardiac complications (such as angina, further infarction, symptoms of cardiac failure) during convalescence reported more psychosocial difficulties.

Illness Behaviour

Illness behaviour "is the collective expression of cognitive, affective and behavioural responses made by an individual to the challenge of physical illness" (Byrne and Whyte, 1978, p. 485). Byrne and Whyte identified eight dimensions of illness behaviour in survivors of myocardial infarction: "somatic concern" (the main concern was with bodily function and dysfunction but extended to concern with appearance and psychological function); "psychological precipitants" (refers to the recognition that distressing life circumstances existed prior to and may have contributed to the event); "affective disruption" (the affective response to illness disrupts interpersonal relations); "affective inhibition" (unable to express feelings); "illness recognition" (they recognize the presence of a serious illness); "subjective tension"; "sick role acceptance"; and "trust in the doctor" (pp. 486-489).

The social context within which the patient suffers an MI probably mediates the responses to it (Byrne, 1980-81). This belief is shared by Doehrman (1979) who concluded after reviewing the literature pertinent to the psycho-social aspects of recovery from heart disease:

> that social factors such as social class and employment opportunities might be related to a patient's view of his life in hospital and his attitudes toward the future. (p. 206)

The social contexts of 120 MI patients--the same group from which the illness behaviours were identified by Byrne and White (1978)--were examined for influences in illness behaviour and state anxiety. The

patients' occupations demonstrated the most prominent influence: persons in blue-collar occupations "exhibited significantly more anxiety in response to MI than did persons in white collar occupations" (p. 23). Marital status and education also had some effects on different responses to MI. Byrne believes that the results "considered collectively, leave little doubt that the affective and behavioural responses to illness observed among survivors of MI are influenced by the social situation which the patient occupies" (p. 27).

Another facet of the Byrne et al. study was to examine the role of illness behaviour in cardiological (medical) and occupational outcomes following MI. Data were collected eight months after discharge and again two years after the MI. The eighth month follow-up revealed that several aspects of illness behaviour manifested within two weeks of the MI was predictive of the outcome (Byrne, Whyte and Butler, 1981). There was an association between poor cardiological outcome and "somatic concern" and "psychological precipitants"; and between those failing to return to work and "subjective tension" and "sick role acceptance" (p. 97).

Over time the influence of illness behaviour on outcome may vary; likewise, the indices of outcome are numerous, with each assuming varying degrees of importance over the recovery period (Byrne, 1982). Hence, an investigation of illness behaviour and outcome at some point beyond eight months post-MI was indicated--24 months was chosen. In addition to the two aspects of outcome which were investigated at eight months, a third was added: "a subjective assessment by the patient of present satisfaction with progress following MI" (p. 106). The most

prominent association occurred with respect to the relationship between illness behaviour and the subjective assessment. Twenty-four months later, those most satisfied with their progress where characterized soon after MI "by a less pronounced affective response to illness, a less apparent tendency to recognize the presence of illness and to adopt the sick role, and a greater acceptance of medical opinion than those less satisfied with their progress" (p. 110).

There was little evidence that illness behaviour soon after MI related to cardiological outcome. However, some dimensions of illness behaviour, soon after MI, related to occupational outcomes. Those who were still employed at 24 months expressed "greater somatic concerns" (p. 110) than those who had given up work. Those who recognized serious life stress soon after MI changed employment. Byrne feels that the findings related to cardiological and occupational outcomes at 24 months are tenuous. Illness behaviour soon after MI appears to influence these outcomes within the first eight months, but beyond that time the influence seems to be more superficial.

In conclusion, the studies which relate to personal traits demonstrate how the individual acts and reacts to his environment. But these studies do not clarify the nature of the experience he lives through. Nevertheless, the studies seem to allude to the concern that it is the <u>lived</u> experience which has to be better understood with respect to the individual's health status. For example, in the studies which deal with the event of the heart attack, the importance of the notion of time often surfaces as the victim tries to make sense of his situation. Here, too, no attempt is usually made to elucidate the

personal experience of time: instead the focus is on causal relationships which are located in a chronological sequence. Similarly, psychosocial studies tend to identify emotional responses in a categorizing manner but not the lived experience of those states in a more descriptive fashion. Finally the studies which relate to illness behaviour are generally context-deprived. They allude to, but do not explore, the notion that human experience is always situated in a particular context.

Descriptions from the Literature

A personal account of what it is like to have a heart attack is found in A Coronary Event, written by the man who suffered the myocardial infarction (MI), Stephan Lesher, and the doctor who treated him, Michael Halberstam (1978).

At the time of his MI, Lesher, a 38-year-old, hard-working, ambitious Washington correspondent was involved in investigating the Watergate scandal. He wanted out of his marriage because he had fallen in love with someone else, but he could not find the courage to tell his wife. He hated himself for his cowardice. Like most patients who have had a heart attack, Lesher's reactions followed the classic pattern: "fear of death, would turn to anxiety over returning to a normal life, but that would lead to depression and the assumption that life would never be the same"; his emotions "bounced around like a rubber ball" (Halberstam, p. 132).

Lesher was defiant and he pushed himself and the system to the

limit. Two days after suffering an MI, he horrified the nurses by doing push-ups. "Push-ups are a sign that one is not, after all, a cripple" (p. 101). After a while, Lesher began thinking about his situation and made a decision about how he wished to live:

> I was and remain a highly competitive person who drinks, smokes and enjoys work, outdoor games and sex. I also discovered I liked being that way, and I was damned if I was going to allow a heart attack to change any of that. (p. 213)
>
> The question is whether I can choose to exist for the sake of existence. I didn't think I can. Does that mean I don't want to live? Or that I have a death wish? . . . I am never really unaware of having a bad heart; God knows that editors, doctors, loved ones and insurance agents keep me from forgetting it even if I wanted to. But I won't want to or need to. (pp. 215, 216)

When the patient does not comply with the treatment regimen, he is labelled as being "uncooperative" or that he has a death wish. But the above excerpts demonstrate that Lesher made a decision. For him, the quality of life was more important than existing "for the sake of existence." Hence failure to see things from the patient's perspective often results in inappropriate labelling.

Tony Foster (1983) tells of his experience of living through and living with a heart attack in his book, By-pass. Foster was in the aviation business where he risked much and made and lost a fortune. He lived life in the fast lane until the age of forty-seven when he had a heart attack. At that time he was serving a prison sentence for a multi-million dollar deal that went wrong.

For Foster, being in the CCU was like being in a "fish bowl" under constant surveillance. Nevertheless, in the CCU he felt secure because he knew that his vital signs were being monitored. In the hospital he

had time to think about his relationship to his family. A man who was always on the move negotiating business deals all over the world, he had developed a "nodding acquaintance" (p. 81) with his family. Suddenly being confronted with this life-threatening event, he discovered how important they were to him. As he tried to come to terms with his mortality, he saw his children as his passport to immortality. "My children will be the only tangible evidence I shall leave behind to prove that I walked this earth, loved and was loved" (p. 80).

Foster was discharged on the eleventh day following his MI and was told that within two months he would be back to where he was before his heart attack. However, instead of being back to normal at two months, the angina pains (which he had suffered for sometime before his heart attack but were diagnosed as severe indigestion) recurred. This time he knew it was angina as the pains were relieved by Nitroglycerine tablets. What had gone wrong? He had complied with the medical regimen. He concluded "my physical activities and medical supplements had accomplished nothing" (p. 163).

After the heart attack he had become preoccupied with his body. He had "consumed dozens of books concerning these worries"; he had not been this interested in his body since puberty (p. 164). Moreover, the anginal attacks increased in frequency and intensity; he feared becoming a cardiac cripple. He was "popping nitro like peppermint in an attempt to stave off the pain" (p. 181). Any physical exertion or emotional stress precipitated an attack, and he panicked and "felt trapped" within a failing body. When told of the possibility of a bypass operation, he "felt better." It gave him hope; he felt that

something was being done. About six months after his heart attack, he had the operation.

Cousins' (1983) book, The Healing Heart, is about a different experience. Instead of being dependent and passive, which is not unusual for cardiac patients, he took a very active role in his care. The book is about a therapeutic alliance between the patient and the physician, one in which the patient maintained some semblance of control. When confronted by a major heart attack, Cousins used himself as an experimental subject. His beliefs and convictions guided and informed his activities. He succeeded. What accounts for his success?

Cousins had spent most of his professional life in journalism, education, and public affairs; then at the age of 63 he accepted a position at the School of Medicine, University of California in Los Angeles. Here, too, he pursued his interest in the physician-patient relationship and his interest in the biochemistry of emotions. Cousins had access to experts not only at UCLA but also throughout North America, and he consulted with these people in developing his rehabilitation program. He was also knowledgeable about the research. Cousins was able to make choices because he was knowledgeable about his situation and he had the "inside track." Being informed takes time and hard work; hence, Cousins' approach is not for everyone.

What can be learned from Cousins' experience? It points to the patient's essential role in combatting a serious illness. It shows how the patient may maintain some semblance of control. That positive emotions--hope, faith, love, laughter and the will to live--are the antidotes to the effects of panic, foreboding and depression which

often accompany a heart attack (pp. 233,234).

Heartsounds, by Martha Weinman Lear (1980), is an account of the author's reaction to her husband's heart attack. She describes what it was like for her, but we also get glimpses about his experience and what it was like for him. Harold Lear was 53 years old when he had his first heart attack. He was a physician and had given up a thriving practice to go into Public Health. His expectations about his change in practice were frustrated, and he became depressed.

After his heart attack, Lear experienced feelings of helplessness, low self-esteem, and loss of control, and feared having sex. He wanted to quit smoking but he could not resist the temptation not to do so. In the hospital he grubbed for cigarette butts in the Visitors' Room and, after discharge, in the gutters along 5th Avenue (New York City). He knew that his "disgusting" behaviour "had more to do with his self-image than with his simple desire to smoke" (Lear, p. 67). His self-esteem had sunk to such a low level that he was willing to try anything, even to seeing a psychiatrist. He finally sought help for his post-coronary depression.

Lear complied with the therapeutic plan. Within two months of his heart attack he was walking a mile a day even though the weakness and shortness of breath continued. He knew all was not well but his doctor insisted that his progress was satisfactory. Lear's fears were confirmed when at three months he sought another medical opinion. Within four months of his first heart attack, he had another; this one left him crippled because he was now plagued by angina.

> Soon he was living like the classic cardiac cripple; afraid to walk; afraid he might drop dead within steps; afraid even to leave the house. (p.11)

To conclude, the biographic literature provides some insight into what it is like to have a heart attack. In the acute stage it dominates the patient's life. It affects how the patient feels and thinks and what he does. The patient is acutely aware of his body, and of the most minute changes. He suffers from anxiety, depression and loss of autonomy; he is concerned about the future--what kind of future? While these accounts are valuable because they tell something about the experience, no attempt is made in the research reviewed and in the personal descriptions to study the experience in a systematic way; to go beneath the surface structures in order to describe patterns and to penetrate the deeper meaning structures; or to transcend the immediately given by bringing forth the nuances and relations in the text (Kvale, 1984).

CHAPTER 3

A HUMAN SCIENCE APPROACH

Introduction

In chapter 2, the two sources--research studies and biographic descriptions--which were explored revealed a lack of in-depth probing into the lived experience of persons who sustain and live with a heart attack.

The research studies tended to focus on one or two isolated aspects of the experience. In the studies psychometric tests, various types of questionnaires, structured and semi-structured interviews were employed to obtain the data. Hence the respondents were limited in what they were able to share with regard to their experiences. These studies were grounded in the researcher's interest in a particular aspect of the post-MI patient's experience.

On the one hand, the biographical and autobiographical sources, which I reviewed, give us a sense of life. On the other hand, they fall short of getting at the lived experience. The present study, which builds on the biographical, attempts to begin to fill the gap by elucidating the experiences as lived in order to glean insights into and a deeper understanding of living with a history of a heart attack. How do we come to understand lived experience?

The Meaning of Lived Experience

The lived experience is the substance and subject matter of the lifeworld. To reveal the lifeworld of the participants in this study, I shall focus on the accounts which they give of themselves and their relationship to others and their surroundings. What is meant by the lifeworld? For Schutz (1973), the lifeworld is the world of everyday life; it is the realm of the familiar and of that which is usually taken-for-granted. It is the spatiotemporal domain in which we encounter others like ourselves with similar motives and goals.

> The lifeworld is the province of my live corporeal acts; it offers opposition, and it requires exertion to overcome it. Everyday reality introduces me to tasks, and I must realize my plans within it. It allows me to be successful or frustrated in my attempts to actualize my goals. By means of my performance I gear into everyday reality and alter it. (p. 35)

The lifeworld is not static; as it changes, so does our lived experience change. The change may originate either within the individual or it may be forced upon him, and in turn it will precipitate a change in the individual's lifeworld. For example, a heart attack interrupts the taken-for-grantedness of the nature of many aspects of the individual's lifeworld. It is as if the person's world "explodes" and becomes problematic. The situation requires reflection; it must be assessed, explicated, and defined.

At the centre of the lifeworld is the body. It is through the body that we meet others and are situated in the world. It is through the body that we affect and are affected by the world. Pre-reflectively, mind and body are closely related and mutually enabling.

> Man taken as a concrete being is not a psyche joined to an organism, but the movement to and fro of existence which at one time allows itself to take corporeal form and at other times moves towards personal acts. Pyschological moments and bodily occasions may overlap because there is not a single impulse in a living body which is entirely fortuitous in relation to psychic intentions, not a single mental act which has not found at least its germ or its general outline in physiological tendencies. (Merleau-Ponty, 1945/1981, p. 88)

It is this bond between the mind and body that is experienced as the lived body.

When attention is brought to bear on the physical body, as happens in a myocardial infarction, how does this affect the experience of the lived body? How is the body perceived? How does having an MI affect the individual's relationship to his world since the body defines one's orientation to being-in-the-world?

Space and time provide the framework within which our experiences take place in the lifeworld (Gurwitsch, 1966). Schutz describes two dimensions to the "spatial arrangement of the everyday life-world" (1973, p. 36): the world within actual reach and the world within potential reach. The latter has two sectors: the world within "restorable reach" and the world within "attainable reach" (pp. 36, 37). The world within actual reach is where we are located in space; it is the ground for our immediate experience. The content of this world is subject to constant change due to our movement within it. Any movement is a change. The world within attainable reach was never within reach, but lies within potential reach. That it can be brought into reach depends upon a number of factors including "degrees of probability" and "grades of ability" (pp. 38, 39). The world in restorable reach is that sector which was once within reach; it is that which was left

behind as we changed our orientation in space, but it has the potential for being reinstated if we return to it. It is within potential reach.

The matter of the world within restorable reach with its potential for reinstatement, as the world within actual reach, is not possible for the post-MI patient by returning to a particular space. That latter space belongs to his pre-heart attack lifeworld; his heart attack places him within a changed lifeworld. Admittedly, after discharge from the hospital the patient returns home, and at some time in the future possibly to his work place. But the place he returns to is not the same place that he was in before his heart attack. That place, by the nature of the change within the patient, acquires a different contextual meaning.

The post-MI patient's return to work, in the sense of Schutz, means that the world within restorable reach is reinstated. Intentionally or unintentionally, this is the way his co-workers view the situation; with time they expect him to be and to do what he was and did before, and this may be impossible. His inability to reenact his past behaviour may become a source of tension between the individual and his co-workers. But it is not only his co-workers who may expect him to perform as he did before. He too may harbour this expectation; and when he finds that it is not realistic he may become very frustrated, angry, and depressed.

While Schutz focuses on space as a structure of the lifeworld, Bollnow (1961) explores the problem of lived space. He focuses on the concrete living space. Bollnow distinguishes between inner space and outer space. The inner space is the "house." There the individual

"roots himself tight to the ground" and "by means of its walls . . . carves out of universal space a special space and thus separates an inner space from an outer space" (p. 33). Man dwells in this inner space; it is a place of security and in it he can return to himself. The outer space "is the space of openness, danger and abandonment" (p. 33). However, the inner space loses the quality of the space for dwelling if he cannot escape it:

> He must go out into the world to transact his business and to fulfill his role in life. Both security and danger belong to man, and consequently both areas of lived space, as life develops in the tension between outer and inner space.(p. 34)

Thus the possible human experience of inner space and outer space show that we have different ways of existence. These modes of existence are related to the experience of space.[2]

The sense of security and danger which is inherent in the individual's experience of his space is most significant to persons who have had a heart attack. The dichotomy, however, does not always hold. It seems that in some places the post-MI patient experiences a sense of security and a sense of danger simultaneously. Moreover, he feels secure in a place (the CCU) other than in the inner space of his home where he dwells. A place may offer security, but in it he is unable to return to himself, so again another contradiction. The following excerpt illustrates these contradictions:

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[2] H. Danner (Seminar, University of Alberta, June, 1986)

> To the patient the Intensive Care Unit, with its complicated equipment, can be frightening. On one hand, the patient feels observed and protected to the highest degree possible; he knows that he is in the unit precisely because he is in the greatest danger. But the entire surroundings, staff, and equipment can be upsetting. He wants to be there to be helped, but he also wants to leave for a calmer setting as an assurance that he is not in danger. It is often at this point of transfer that he becomes anxious. In our experience this rate of transient anxiety is quite high. (Blancher and Joseph, 1972, p. 390)

Anxiety has the potential for restricting one's space, as there is a tendency to remain where one feels safe and not to venture out into the unknown.

From the above it becomes apparent that these spatial arrangements of the everyday lifeworld bear the temporal character of the past, the present, and the future. That which is within restorable reach is related to the past, within actual reach to the present, and within attainable reach to the future. In addition, the above reveals that the lifeworld is not static. It changes as we orient ourselves in space and time.

One of the consequences of a heart attack is that it may change the perspective of the three temporal dimensions. The past is reconstructed in terms of the present as the Levy (1981) study demonstrates. The present "now" is not the one that was anticipated; this in turn changes the perception of the future, at least the foreseeable future.

> The lifeworld is built upon three dimensions of time: the subjective time of the stream of consciousness (of inner duration) intersects within the rhythm of the body as "biological time" in general, and with the seasons as world time in general, or as calendar or "social time". (Schutz, 1973, p. 47)

There is no absolute congruence between these dimensions, hence, the

phenomenon of waiting is the inevitable consequence of this incongruence (p. 47). The heart attack patient may be acutely aware of the phenomenon of waiting. Within days of the event he usually feels rested and is ready to resume living, but he must curtail his activities until his damaged heart heals. This takes about eight weeks. Moreover, because of the subjective dimension of time, we each have our own specific time; the length of the day varies for each of us, and for each, from one situation to the next.

Plans are related to time, and time to plans; a change in plan effects a change in time (van den Berg, 1970). Van den Berg raises the question: "What is time without a plan?" (p. 104). For him, that would be time without content. How can this be? Plans and action are an integral part of the lifeworld. If this is correct, what happens when the plan is developed and imposed on the individual by someone else? I am referring to the patient's experience in the acute and early convalescent phases of his illness. If the patient is not involved in developing the plan, is this for him "time without a plan," a void in his life? Is this the basis for denial of the event?

We live in the present; the past and the future are embodied in the present (van den Berg, 1974).

> The past is within this present: what was is the <u>way</u> it is appearing now. <u>The future</u>: what comes, the <u>way</u> it is meeting us now. This appearing and meeting are closely connected. . . . the past is that which lies behind us, but only because a future permits it to lie there. And the future is indeed yonder, before us, but only because it is fed by a past. The present is an invitation from out of the future to gain mastery over bygone times. (pp. 91, 92)

The past informs the future, therefore, the future can take a different direction. We are not tied slavishly to the past; it is within our

power to act differently in the future. Thus what happens in the present is influenced by the past and by our expectations for the future.

We are aware of our finitude and that we have a limited time in which to realize our goals. This motivates us to act, to overcome obstacles. A serious illness such as a heart attack, which strikes at the very core, often forces the individual to appraise critically his goals. It may necessitate a change in priorities, a change in life objectives.

The foregoing addresses time more as a structure of the lifeworld than as lived time, as seen in the use of words such as plan, goals, finitude. To acquire a sense of lived time is to get in touch with the rhythm of life, its cadences and its continuity which are lived simultaneously. Ballard (1975), in his search for an example to capture the notion of time as a whole, refers to the heart disease patient who is concerned with the rhythm of his heartbeat:

> as he delicately feels his pulse, [he] wonders "will there be another?" for he, surely, is aware of the living phases of his heartbeat and the recurrence of his pulse as a sine qua non of time. (p. 179)

Wessman and Gorman (1977) point out that "the phenomenal experience of time is not merely a series of discrete and disconnected 'nows'; rather it generally unfolds in continuing, interrelated and meaningful sequences" (p. 41). Moreover, time cannot be apprehended in itself because as van den Berg (1970) says, "time as such is not and cannot be seen. Time as such is not real. What is real is the changing of things, their dimensions and colors" (p. 113). For van den Berg, time is in things. This is in accordance with the notion of

rhythm, as there is movement in rhythm and hence, change. Thus time is as much in things as it is in human beings as we change. Hence we are in time.

We live our everyday lives in interactions with others and with our environment. We are always in a relationship with others or to things. Heidegger (1926/62) reserves the word "concern" for our relationship to things and "solicitude" for our relationship or "being-with" others. There is a negative and a positive dimension of solicitude; the former manifests itself in indifference: "With regard to its positive mode, solicitude has two extreme possibilities . . . that which leaps in and dominates and that which leaps forth and liberates" (pp. 158, 159). That which dominates is characteristic of what Buber (1958) refers to as an I-It relationship. The individual becomes a thing among things for the other. Hence the relationship is predicated on concern, for concern speaks to our relationship to things; in this situation the individual becomes a thing. The other then may become an obstacle for the individual to realize his potential. "Instead he becomes what the other wants him to be" (Buber, p. 6). Consequently, the other has the potential for distancing him from himself and from his world.

That which leaps forth and liberates is characteristic of what Buber refers to as an I-Thou relationship. In the I-Thou relationship, "we relate totally to the other and we do so by becoming open to him" (Macquarrie, 1972, p. 108). This is predicated on caring. What triggers the caring response in the other? Zaner (1981) notes that affliction "solicits notice and provokes a special alertness; to be cared

for" (p. 39). Affliction, however, is only one of many dispositions which begets caring; but it is the one that is most relevant to this inquiry. The afflicted, however, has to experience the other as caring.

The heart attack can become the occasion for building bridges or fences between the post-MI patient and the other and also between him and his world. This depends upon how he experiences his being-with-others. The other is like a mirror; he looks for cues which reaffirm or discount him as an individual. Van den Berg (1974) captures the nature of the human encounter when he says:

> A word, a look or a gesture can brighten things or make them gloomy. The person with us is not another isolated individual, next to us, who throws words in our ear and who remains foreign to the objects around us. He is the person who is either with us or not with us and who makes the degree of togetherness or distance visible in objects, concretely and in reality. (p. 65)

How does the other create nearness or distance? How does the post-MI patient take his stand in relation to the other?

Researching the Lived Experience: Description/Interpretation

To research the lived experience is to go beyond the taken-for-grantedness of the world of everyday life. It is to be attentive to the uniqueness of a particular person in a particular situation. It requires that "we describe and interpret human existence in its dialectic bond with other beings" (Strasser, 1963, p. 275) in such a way as to discover the meaning of the lived experience (van Manen, 1984). The descriptions are contents of experience, and interpretation the act of

mediation between the interpreter and the interpreted (Silverman, 1984).

It is through language that we seek access to the other's experience. Language transports us into the other's world; it gives us access to how the other feels, thinks, and reacts. It is the way for sharing the subjective experience. My approach, however, involved more than obtaining descriptions of the experience of sustaining and living with a history of a heart attack; it required reflecting upon the experience so as to discover the subtle and hidden forms, that which speaks to the experience. This is necessary for understanding:

> A person who seeks to understand must question what lies behind what is said. He must understand it as an answer to a question. If we go behind what is said we inevitably ask questions beyond what is said. (Gadamer, 1960/1984, p. 33)

For the purpose of this study, it was necessary to reflect upon the text of the conversations in which the participants and I engaged so as to gain insights into their experiences as post-MI patients. This meant returning to the text again, and again, and exploring it from different perspectives. It involved a thoughtful questioning of the experience, questioning which sought to open up the topic of living with a history of a heart attack.

Reflection goes beyond "hearing" what is said. It is an attentive listening; it is listening to the intentions behind the words. For example, Mulder (one of the participants), in describing his heart attack, said, "I knew something was really wrong. . . . I really thought I was going to die." What was this knowing? Did he really believe that he might die, or was this a way of saying that he perceived the situation to be very serious, that it could have enduring

detrimental effects to his well-being?

Interpreting, from the researcher's perspective, is the act of making sense of what has been said; it seeks to make clear that which is obscure, to make explicit the "implicit message." This is necessary for understanding of what life is like after a heart attack. Interpretation involves a movement from the part to the whole and back to the part again; from a statement which seems to speak to the experience to the text as a whole. For example, using the Mulder story, what did he mean when he said:

> I tried to walk slowly in the beginning. I really felt old, because I could not walk normally. . . . I realize how bad traffic lights are for older people. Because they change and you have to hurry up.

In order to grasp the meaning of this statement, it is necessary to return to the text as a whole to explicate his beliefs regarding those who are vulnerable to heart attacks, to ascertain what he sees as the consequences, and to determine what his past experiences have been with persons who have survived a heart attack. In other words, the statement has to be located within an historical and contextual perspective in order to make sense of it and to come to a deeper understanding of what he meant when he said, "I felt really old."

The Conversations

The primary question which seeks to elucidate the experience of sustaining and living with a history of a heart attack directs us to persons who live this experience. Their stories become the ground for

this inquiry. I engaged in interview-conversations with seven males who had a heart attack at least two years previously.[3] An interview-conversation is neither strictly structured with standardized questions nor is it "entirely non-directive." Instead, it focuses on a particular situation or event (Kvale, 1984, p. 176).

I shared with each of the participants my interest in learning about their experiences. Thus I encouraged them to tell about the event and to speak of their lives since. I had formulated a number of questions[4] which were not asked verbatim but were used to guide the interview-conversations. I was acutely aware, however, that the questions must not be isolated from the original question: What is it like to live with a history of a heart attack. The questions must maintain their situatedness within it "and thus be constantly oriented to the lived experience that makes it possible to ask the 'what is it like' question in the first place" (van Manen, 1984, p. 45). In many instances, the questions were spontaneously covered by the participants. If they were not, I asked them at an opportune time.

Most of the interviews required two one-and-a-half-hour long sessions with each participant. The conversations took place from five to ten days apart. They were all tape-recorded and transcribed. Following each session, I listened to the tapes and explored them for themes. My interpretations were shared with the participants for further exploration of meaningful aspects of the experience. The

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[3]See Appendix B for Interview Schedule

[4]See Appendix C

conversations took place in my office between June, 1984, and February, 1985.

Finding Participants

Seven men were interviewed in this study. One person heard about the study and contacted me, three volunteered after I explained my project to a cardiac rehabilitation exercise group, and the other three were suggested to me by classmates. With this latter group of three, my contacts made the initial approach to the potential participants. In all cases--except in the situation when I was contacted--I followed up with a telephone call to explain the nature of my study and to express an interest in the prospective participants' stories. I repeated the explanation again when we met for the first interview, and as they agreed to participate and to have the interviews tape-recorded, they signed a consent form.[5]

The Stories

The participants' experiences of living with a heart attack are the sources from which their stories are drawn. It is through the individual's story that we gain access to his experience. A story, Novak (1978) says, "is a narrative that links sequences. A story is a structure for time. A story links action over time" (p. 49). Thus a

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[5]See Appendix C The Informed Consent

story has a focus and it has a beginning and an end, but the interpretation of the story is unending. Each time we come to the story we approach it from a different standpoint. Making sense of the stories in this study is just a beginning. It represents a view at a particular time and from a particular situation.

A story "is an interpersonal construction" (Kotre, 1984, p. 29) of the teller and the listener. The stories which are told in the following chapter are a co-creation of the participants and me. A story is usually spun around a central theme to which listener and teller are directed. In this study we were guided and directed by the question of the experience of living with a history of a heart attack. The teller brought to the story his personal experience, and I brought my experience of working with persons who have had a heart attack and my insights and understanding of that life experience. As the participants told their stories, I attempted, when appropriate, to move the teller from the manifest story to the latent story by sharing my reflections and interpretation and by asking for clarification when necessary. As Kotre points out, stories come in many layers:

> There is the manifest story, a public version of the life that includes the basic biographical facts, the outer journey. Beneath this is the latent story, the private version that depicts the inner course of life. The latent story has many levels, some of which are slowly revealed to the speaker and me, some of which remain hidden. (p. 29)

I believe that the persons who volunteered to share their stories with me did so because they wanted to help me with my project. They were in no way obligated to me: we came together as total strangers; we had no contact before and have had no contact since. I believe that

they were open and candid with me. The majority volunteered that they had never discussed their experience in this way. During this first interview, one of the participants said that his heart attack did not change his life in any lasting way over the long term. But just before the end of the second interview, he made this unsolicited comment:

> Just thinking back to what I said, it really does have a big effect on your life. Maybe I am wrong to play it down. It really does have an effect far beyond what you would normally think when you start to look at it in these terms. I have never really had to put it in any coherent order. This is quite an exercise for me because I have never tried to re-order it in any sort of coherent and analytical kind of a way. That's interesting in itself because mostly I would try to do that in other things, but I haven't done it in this.

Each story captures the uniqueness of a particular individual. But the stories, which are recorded in this study in the form of reconstructed narratives (chapter 4), may be viewed as subplots in the story of a man's life. A person's life story may be made up of many stories and not just one all-encompassing story. To ask about the experience of living with a history of a heart attack is to ask about one of the subplots of the individual's life story because there are other ways of viewing his life as, for example, from the perspective of being a man, or a father, or a husband. Each of these standpoints will present a different story, yet these stories are not isolated from each other. They are all interrelated and to some extent shape and give meaning to the particular viewpoint which is being explored.

Interpreting the Stories

As I reflected upon the reconstructed narratives which were derived from the stories, each seemed to capture a particular aspect of the lived experience. Moreover, the particular narrative spoke to different dimensions of the experience more fully than the other stories in which they were also found. Thus stories which captured a particular aspect, for example lived body, provided the structure for developing the descriptions. In other words, the dimensions in one way resemble themes in that they can be seen as "knots in the webs of our experiences, around which lived experiences are spun, and are experienced as meaningful wholes" (van Manen, 1984, p. 29).

The transcripts, reconstructed narratives, and the literature were searched for exemplars of each dimension of the lived experience so as to develop the descriptions. These elucidated the participants' experiences. The descriptions yielded the experiential characteristics. The experiential characteristics are statements of a general nature which summarize recurring motifs of the participants' experiences of sustaining and living with a history of a heart attack. The experiential characteristics are themes in possible human experiences; they are not universal essences.

Writing

To create insightful descriptions and to illuminate what life is like after a heart attack requires a style of writing that has an

evocative quality. This style facilitates, through thoughtful questioning, going beyond what is said and thereby has the possibility of uncovering the hidden meanings which enhance understanding of the experience.

The participants' stories of their experiences are presented in the form of a "reconstructed narrative." It is referred to as a reconstructed narrative for two reasons. First, the conversations are not reproduced in toto; they are condensed. However, the excerpts are presented verbatim. Secondly, the sequencing of the experience follows a temporal order which does not normally occur to the same extent in a conversation. That is, a topic or an issue is often returned to again and again throughout the conversation. What I did was to begin with the heart attack and develop it as fully as possible, before moving on to the hospital experience, the convalescent phase and the individual's present situation. Interspersed throughout the reconstructed narratives are commentaries which represent the beginning phase of reflection and interpretation.

The descriptions in chapters 5 to 8 inclusive are structured in terms of the existential themes of corporeality (lived body), sociality (living with others), temporality (lived time) and spatiality (lived space) respectively. Within this structure the examples are varied in an attempt to glean insights and understanding.

Organization

Chapters 1, 2, and 3 situate this study in terms of the evolution of the question, my stand in relation to the question, sources on the one hand which bring us closer to the experience but on the other hand tend to obscure the experience, and my orientation to the inquiry. Chapter 4 displays the particulars of the individuals' stories[6] in the form of reconstructed narratives. In chapters 5 to 8 the descriptions, which are rooted in the transcripts, the reconstructed narratives, and the literature are probed to reveal the experiential characteristics. Chapter 9 explores the implications for health care practitioners of the insights and understanding of living with a history of a heart attack that emerged from this study. I also look at some of the implications of the mode of research exemplified in this study for nursing research.

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[6] I have used pseudonyms instead of the participants' names and have disguised certain identifying details in the stories while leaving their contents unchanged. This has been necessary to maintain anonymity of the persons concerned.

CHAPTER 4

RECONSTRUCTED NARRATIVES ABOUT LIFE AFTER A HEART ATTACK

Introduction

> What is a story? A story is a narrative that links sequences. A story is a structure for time. A story links action over time. . . . A story does not merely connect action to action. It also recounts a struggle. (Novak, 1978, p. 49)

The participants' stories speak to sustaining and living with a history of a heart attack. The stories begin with the event and progress through time to the present. In the stories we see a struggle unfold. The struggle may be rooted in the fact that the post-MI patient is at one and the same time a victim and a survivor. At first there is the struggle to survive. The struggle continues after with the question of "Why me?" There are struggles with health care professionals, with family, with co-workers, and with one's very being.

Let us now turn to the seven persons who shared their stories.

DIRK MULDER

When Mulder had a heart attack in the early 1970s, he was completing his dissertation and teaching at a university in a large

European city. I began my interview with Mulder by asking, "What is it like to have a heart attack?" His immediate response was, "HORRIBLE," and he laughed. I wondered about this; the laughter seemed inappropriate. Did my question pose a threat? Was it too direct? Nevertheless, Mulder continued:

> I was running to the bus, getting out of breath. I took the bus to the station and in the train I realized that something was wrong. There was a heavy, burning feeling in my chest, a very severe pain; and I really thought I was going to die.

At first it was difficult to distinguish the symptom from a "normal" response to running. Moreover, the usual self-forgetfulness of the body which loses itself in behaviour directed towards the situation, in this case running to get the bus, was eradicated. The body protested loudly, it cried out for help, it sounded the alarm. This could be the end. Although Mulder was acutely aware of what was happening to him, he was not oblivious to his surroundings:

> I really thought it would be embarrassing if I should die in the train. I was really concerned about that.

Death dissolves the union between the body and that which gives life. The body without life is but another object, a thing among things, to be stared at or treated in the same way that other objects are treated. To have this happen in a public place, to be witnessed by strangers, is a disturbing thought.

Did Mulder think that he had had a heart attack?

> No, I did not know what it was. No idea. No, I really didn't. But I knew it was something serious. On arriving at my friend's place I was very tired, and I knew that something was really wrong. The severe pain was gone; now it was a lingering kind of pain. It was just here [he points to the lower left border of his sternum], the centre. I said to my friend, "I had better see a doctor."

The "something serious" that threatened to destroy his life was still nameless. Even today he remembers how tired he felt. The tiredness, like the pain experience, was a different kind of experience. He had felt tired before, but it was not like this. The pain which interrupted life's activities became the centre of attention and, while it lost its sting, it stayed. It became a source of concern; it preempted everything else. It demanded action. The visit with his friend had to wait, for he had to seek medical attention:

> It was Saturday evening. I took a cab to the doctor's office. He did not think it was something serious, although I really complained about the pain. So he gave me only a pain killer. It helped the pain; I slept well that night.

Mulder felt that the situation was serious, but this feeling was not shared by the physician. In an attempt to stress the gravity of the situation, Mulder "really complained about the pain." How else could he make his point? This was to no avail. The medication dulled his senses and there was a respite. But nothing changed--the cause of the pain was still unknown. When would it recur? The pain was a symptom of an underlying problem. What was it?

His neighbour visited, and he too saw that all was not well. He said, "You do not look well. You should see a doctor," to which Mulder responded, "I will go. I feel really sick, and I do not know what it is."

Mulder sought a second medical opinion. This time he saw his general practitioner:

> I remember going to the doctor. It is only a fifteen minute walk. Normally, I am a brisk walker. But halfway there, I thought I am not going to make it, so I stopped a car. This is very unusual in the middle of the metropolis. A man

> stopped and I said, "I want to go to my doctor, and I am not sure that I am going to make it." He replied, "You look okay." I said, "I really feel I might not make it. Can you take me there?"
>
> He did. I was really aware that I was sick but not acting as though I was.

When the "scars" of an illness are not visible, the individual's "healthy" appearance may create a dilemma for him in time of need. Mulder's behaviour did not fit the mould.

> My doctor, a very nice woman, did not know what it was. She thought it was stress-related. She noticed I was anxious. She phoned her friend, an internist, and said, "I have here a Mr. Mulder. He is working on a thesis. I think he works too hard, but as he is very anxious, I think you should see him. Can you see him this evening?"

This was Mulder's second encounter with a doctor whose view of the situation was not congruent with his. Was his anxiety, which the general practitioner diagnosed, due to his inability to convince the doctors that something was really wrong? "I was afraid I had something real bad." Now Mulder was on his way to see a third doctor in as many days:

> As I entered the room, the internist said, "Sit down. I shall make you a cup of tea, and then I shall take you to the hospital." She saw it in me. And from that moment on I felt even sicker. She said, "You are really sick. I think it is a heart attack. I am not really sure." She took me to the hospital in her car.

What did he mean when he said, "she saw it in me"? What did she see? Something seemed to have invaded his body. His body had become an object, a prey to disease. It was under attack. This intruder which now shared his body made him feel even more vulnerable.

I wanted to know what his reaction was to the diagnosis because he had such difficulty convincing the doctors that something was "really

wrong."

> I just gave up, I think. I just thought, that's it. I do not have to do anything more now. I was really constantly trying to convince people that I had something serious. They did not believe me--including two doctors. I was telling them that, "I am sick and you are not doing anything about it." The first doctor, not at all. The second made a referral to the internist, but told her on the phone, where I was sitting next to, that I was just nervous or perhaps worked a little too hard. Maybe. And I knew it was serious. There was no doubt in my mind. But I didn't have any idea of what it could be. I was really not prepared to have a heart attack, mentally. Never thought about it. I was afraid of cancer or what else. I don't know, maybe it was just cancer. Yeah.

The diagnosis intensified the sickness experience.

> Yeah! Now I really felt sick; before I felt sick, but I was still climbing the stairs and doing things like that.

What was it like to feel "really sick"? Was it like being an invalid now that he could not tolerate physical activity? The diagnosis is a catalyst for change; to begin with, one becomes a patient with all the expected sick role behaviours. The diagnosis of heart attack changes the way one thinks about oneself and alters others' perceptions of the victim. It necessitates lifestyle changes. Mulder's immediate reaction was to localize the problem.

> Then you localize it immediately. As she said, "heart attack" I really felt it was my heart.

The heart is the core: "it is seen as the centre of life and vitality. It is also the origin of sudden death" (Levy, 1981, p. 155).

> It's in the middle of your body and you really feel that you are dependent upon it. So, I think it is one of your central organs. All your other capacities are debilitated by it, even later. Whatever you do. You know reading is tiring, and I like reading. Watching TV is tiring. Everything is tiring. I used to watch TV to relax. [He laughs.]

With the realization that he had had a heart attack, then the question

was, how will it affect his life.

> I was afraid I would not be able to lead a normal, working life. I was just starting to do some scientific work, and I was working hard on my thesis, had maybe half of it completed, possibly the first draft. I was also working with students and had some administrative responsibilities. I was working too hard, much too hard. That was really too much, but I enjoyed it. I enjoy an active life. So the prospect of having a quiet life was not attractive to me.

Recovery is more than just existing: it is living life to its fullest. It is being able to work and to be independent. It is being able to do what you want to do when you want to do it. It is the desire to be normal again.

> In the beginning you are confined to your bed. Your world becomes so small, you become so dependent on people. And I hate to be dependent. That was really hard for me.

Mulder lives alone. His sisters, who live in another city, were very concerned about who would take care of him immediately after discharge, when he would still have physical limitations.

> My sisters were very concerned about who would take care of me. They said, "You can come to our house after you are discharged." I think nobody was thinking that I was going to die, me neither, after that. I was very depressed the first two weeks, especially as I thought I would not be able to live a normal life, and I thought, "I do not want that."

For Mulder, being an invalid meant:

> being physically dependent, not being able to do what you want to do, and not being normal, and not being able to work. Being physically incapacitated and not being able to carry on with my work. Always being careful.

His goal was to be normal again:

> I wanted to be normal again. I wanted to work. And I enjoy life [laughs]. Yeah, I enjoy life, my field of study, the people I know and love. That is important to me.

What does it mean to be "normal"? Normal in relation to what? Mulder had a heart attack, so it is impossible for him to return to his pre-

heart attack condition. Did he mean that he wished to be able to do the things he was able to do before he had his heart attack? Is that what being "normal" is for him? But what if he were left with limitations and could not be normal again according to his standards?

> I did not think about suicide, but I was really thinking that this is not the life I want to live. I was very definite about that, and I still am in a way.

Mulder volunteered, "I did not think about suicide." In spite of this comment, is it possible that he saw taking his life as a possible option? He was very definite in this conversation that existing for the sake of existing was unacceptable to him.

Mulder looked for signs of improvement, for movement away from "invalidism" to being normal again. He measured his progress by:

> being able to walk for longer distances, to put my clothes on quicker, to be able to climb the staircase with care, and to survive crises. I remember in Funchal [he was there about four to five months after his heart attack and before returning to work], to get the bus I would have to walk about half a mile, but if I used the stairs [a shortcut], it would greatly reduce the distance. I decided to try the stairs. Halfway up I thought, I am NEVER going to make it. And I should not have done it, but I went on. The next day I decided to take a cab because I thought I am crazy to climb the stairs. But I felt rather confident I had survived. I think every crisis you survive makes you more confident.

So overcoming a crisis is an important step on the road to recovery, to being normal again. But in the meantime it takes courage; you fear falling behind, not being able to "keep up with the pulse of the big city." Even crossing the street is an ordeal. It took Mulder longer to cross because if he walked briskly he would experience chest pain.

> I tried to walk slowly in the beginning. I really felt old, because I could not walk normally. . . . I realize how bad traffic lights are for older people, because they change and you have to hurry up.

Mulder said he felt old. If he had had a broken leg and could not walk briskly, would he have felt old? Or is this feeling related to his belief that it is older people who have heart attacks? (He disclosed this in the interview.) If you have a heart attack, you must be old--you feel old.

Mulder knew people who had had heart attacks who were "too soft on themselves, and they did not recover. They remained invalids." But others can be unreasonable in their demands. You may be expected to do more than you are capable of doing, so you have to take care of yourself, to defend yourself. At times it seems as if it is you against the world. But you must not pamper yourself; you must strike a balance.

One place where you have to maintain this balance is when you return to work. Going back to work does not mean that you are normal again.

> As soon as you are back in the work place they think you are normal. I could have done a lot of work on the condition that they didn't exhaust me. And still they make demands on me that I think I should not respond to because they don't realize I have had it. And I think I should not do it.

Going back to work, while it is a positive sign, is nonetheless problematic. You are not "normal," even though you return to work, because you are unable to engage in all the activities which you did prior to the heart attack.

> After a few months they forget. But you have to defend yourself, but you cannot be too easy on yourself.

One has to strike a balance between what others demand and what one is capable of doing. One has to learn to say "no" to unreasonable de-

mands, and this is difficult when dealing with colleagues. A heart attack is a source of tension between the "patient" and his colleagues.

> Sometimes people still do [make unreasonable demands]. Then I think,"don't you know I have had a heart attack?" But they don't know. They really don't know, even if I tell them. They forget. They really forget it, so it's no use. They think I am inconsiderate; sometimes I have to accept that. But it bothers me because I think I disappoint them, but I cannot help it. So I have to accept it.

The experience of having a heart attack remains. It is an indelible and inescapable part of the individual--he knows what it is like. Others who have had the experience also know. They understand. Does this mean that unless you have had a heart attack you do not know what it is like? Is this the reason why we forget even though we know someone has had a heart attack? This makes communication and cooperation difficult in the work place.

Behind every chest pain lurks the ghost of another heart attack. The fear of another heart attack lingers on for some time; maybe it never disappears. But there is an additional fear, which is that you may not get the assistance you need when you need it.

> Whenever I felt a pain, I was scared and I would ring the bell. They [the nurses] came in about half an hour. By that time the pain was usually gone. I was afraid that I would have another heart attack. That fear stayed with me for a few years.

> If you get a chest pain, you think maybe it is another heart attack. I remember one evening, two months after. It was late at night. I was afraid I was having a heart attack. I felt very weak and very bad, so I phoned my doctor. The internist. She could not make house calls; that was not allowed by the system. So I had to call my general practitioner. She came. That I realized later was exceptional: she borrowed an ECG machine from her friend--the internist--and did an ECG. I did not have a heart attack. I was satisfied. That was the only time I was really afraid for more than just a moment.

Some people experience angina pectoris, a temporary discomfort which ceases when the individual rests and/or takes a vasodilator such as Nitroglycerine. Mulder was never convinced that the medication made a difference, but he hoped it would.

> I had these nitros. They never really helped me. I took them out of thinking that they helped, but they did not--mostly it [the chest discomfort] went away. If I stayed still for a few moments, then it went away.

In spite of the fact that Mulder was not convinced that the nitros made a difference, he always had a supply with him as directed by his physician.

> I used these nitros for two or three years. I was always scared if I did not have them with me, even though I knew they did not really help.

For Mulder, having angina in a public place was an embarrassment and he paced himself so as not to precipitate an attack.

> In the beginning you avoid effort and you become very attentive to it. If you can avoid climbing stairs you do, because climbing stairs is very heavy, and you have to take things in phases. If you have to take a staircase, you climb a few stairs at a time and then you rest. You pretend to look around. I did not want to be obvious. People ask, "Are you not well?" So you pretend, you avoid, you make detours to avoid the stairs. I did.

Sometimes if activities were carried out too quickly, Mulder experienced some chest discomfort and he had to stop and take a nitro. I asked, "What was it like when you had pain and you had to stop whatever you were doing and take a nitro?" He responded, "HORRIBLE," (stated very emphatically). "Yes, I found it very embarrassing and you get anxious--Maybe . . .? Maybe . . .?"

So each incident of chest pain was a stressor because it could mean another heart attack. These episodes continued for some time,

always a reminder of a past event which could recur in the present.

> After two to three years I was back to normal work, and I still had the occasional pain.
>
> But when I went on a year's sabbatical, to another country, I was completely free of pain. I never noticed any pain. Not even in the cold. I know in the cold you have to be careful. You forget about it if you don't have it.

After a number of years, Mulder was pain-free and free of the attendant fear of ~~a recurrence.~~ But there is at least one event that brings back memories of the experience, and that is going for his yearly check-up. In response to my question, "So you never think about your heart attack now?" he responded:

> Oh if there is a reason for it. So in a way I don't like it, to go to the doctor for a yearly check-up. I don't like it, and I never liked it before. No, I think maybe they will discover something. I am not very aware, but I know there is a lingering fear. I have it even for cancer; so [he laughs]. So.

Being careful to avoid activities that would trigger chest pain did not mean that Mulder became immobile. He gradually increased his physical activity; in fact he would push his limits.

> I always went as far as I could and then I always tried to go a little farther. Otherwise you could become an invalid. I really tried very hard not to be one.

Mulder's hospital stay was an ordeal for him; he was hospitalized for several weeks. He thinks he had his heart attack either at the end of October or early November and was discharged just before Christmas. What he seemed to fear most about having chest pain was not so much "dying but of going through that again, thinking of going to the hospital. I am still afraid of that."

Going home was going back to the familiar. In a way it was like reclaiming his life, regaining control. Mulder felt even safer there

than in the hospital. Why? He did not know.

At home, Mulder paced himself. He knew his limitations. At first he "did everything very slowly, being very careful, taking my time to get dressed and things like that." His meals were prepared and delivered by a commercial enterprise, and his neighbours did his shopping. Mulder watched television, read, and slept. Whenever he felt weak he would lie down. He stayed at home until mid-March, except for daily walks. He increased the distance walked gradually. Then before returning to work, Mulder went to Madeira for a vacation and there he continued his rehabilitation programme of rest, relaxation and daily walks.

How did Mulder's heart attack change his lifestyle? He describes his life as being "more regular":

> I sleep better. Once in a while I will not get enough sleep for one night, but then I make sure that the next night I make up for the lost sleep. I am usually in bed before midnight and I sleep until eight a.m. For a year after my heart attack, I rested for an hour each afternoon. I had a couch in my office. It is still there, but I never use it.
>
> I walk every day, and I feel good. I know that the research proves that you feel much better, but you do not live longer. So it is not such a necessity. Before my heart attack I always walked, but I did not do it regularly. If I feel stressed, I go for a two-hour walk.

Mulder altered his eating habits. In addition, he now drinks less coffee than he used to. Before his heart attack, Mulder drank up to twenty cups per day. Altering eating habits can be extremely frustrating for many heart attack patients; many fail over the long term to maintain the changes which they instituted during early convalescence. What accounts for this failure? Is it easier for a single person than

a married person to maintain the changes? For the married person, it may mean that the entire family will have to change their eating habits, which they may resent; the alternative is to prepare separate meals for the post-MI patient, which means extra work.

Prior to his heart attack, Mulder worked very hard. "I was working too hard, much too hard, doing scientific work, working with students and running the Academy." Now he sets limits. He goes to the Academy three days per week; the rest of the time he works at home. Mulder usually resists all demands for early morning meetings because this interferes with his need for sleep. Having a heart attack has made it easier for him to say "No" to unreasonable requests. In addition, he takes more vacations.

> I never used to take all my holidays. I really didn't care. Now I take more holidays. I take two holidays and an extended winter holiday. My doctor insists that I go away twice a year for more than just a week. So I started to take three weeks in the winter. I travel everywhere. I have been twice to Majorca, once to Tunisia, four times to Malaysia and Thailand.

In order to facilitate relaxation, Mulder took private yoga lessons. "I took private lessons because I wanted to take them for relaxation and for my heart."

> I took these lessons for half a year. If I feel tense then I can relax. And I still do three or four exercises in the morning.

Before Mulder's heart attack he smoked "forty cigarettes per day, sometimes fifty." He no longer smokes.

OREST RADOWSKI

It was Friday, July 29, 1982; Radowski was driving home from work, at noon, when he experienced a pain in his left shoulder. This pain was accompanied by what he described as "feeling sick to my stomach." When he arrived home, he rested for awhile. He thought the discomfort would go away, but it did not. Radowski took a sip of water, but he could not swallow it. "It just stayed in my throat." Then "I did get sick to my stomach. Twice I think." He also had cold flushes:

> And a real pain in my left chest, as if someone was drilling me. That kind of pain. A bad pain. Then I think I just about fainted. Came pretty close to that . . . I lay down for awhile and I tossed and turned. I think I screamed and everything.

The pain seemed to originate from an external force, it was "as though someone were drilling" him. A pain that seemed to pierce him to the centre of his being, a pain that he could not overcome, it had subdued him. He needed assistance. He phoned his wife. She came home from work, and together they went to the hospital. There he was diagnosed as having had a heart attack. How did he react to the diagnosis?

> Well, I didn't believe it. I said, "No." I said it couldn't be me. . . . I always felt good. I kept myself in shape all the time. Exercised and things like that.

As our conversation progressed, it became apparent that Radowski thought that one day he would have a heart attack. He felt that his heart was "not working right." The outcome, upon reflecting on the event, seemed inevitable. Seven years prior to his heart attack, Radowski had suffered "light-headedness" and chest pains. He saw a doctor who investigated his symptoms. He even had a stress test. The

verdict was that nothing was amiss with his heart, but he needed more exercise. Radowski, however, did not agree with the doctor's recommendation regarding his fitness level. His idea of what constituted exercise and the doctor's definition were in conflict:

> I did not agree with that at all, because . . . being a labourer you get enough exercise in the building, and when I came home at 4 o'clock, there were days that I was real tired from work; overwork, I would say. And then they tell me I should start running for fifteen to twenty minutes. I did not agree with that at all.

What do you do when you believe that the doctor has erred? One option is to seek another medical opinion. Radowski did not. He said that he did not believe the doctor, but he really wanted to believe him. To seek another opinion could destroy his false hope:

> When the doctor said "there is nothing wrong with your heart," I sort of was happy to hear that; but deep inside me I didn't think he was right.

Moreover, Radowski recalled that his doctor said, "If you are going to die, you are not going to die from your heart."

Radowski describes having a heart attack as "something different." What does he mean by "something different"?

> Your whole life is screwed up after that, it seems to me. When I first had it, I couldn't do what I wanted to do and stuff like that. I thought my heart was gone. That was the way I thought about it. I couldn't, I wasn't going to be able to look after myself because of what happened; but as it is right now, it's okay. At that time I didn't know how I was going to recover from it.

The diagnosis of MI is often associated with fear of death or invalidism. At first Radowski's major concern was for the consequences of the heart attack in terms of returning to a normal life. He feared becoming an invalid, not being able to look after himself. It would be

difficult to ask for help when he had always been independent. And during his stay in the ICU/CCU, it was difficult to assess what he would be able to do because of the enforced immobility. During the first two days in the CCU:

> What really bothered me more than anything was if I do come out will I be able to do as much as I did before? That was what I was mostly concerned about.

Getting out of bed for the first time, while it is a sign of progress, may not be a momentous occasion; it may actually reinforce the individual's feelings about becoming a "cardiac cripple."

> When you begin to move around your heart rate starts jumping, going up and down. So you have to really watch what you do for the first while. You feel it. You don't have to take your pulse, you know.

Normally we are unaware of the constant pumping action of our heart, not so for the person who is recovering from a heart attack. He is acutely aware of the changes in rhythm and rate. His heart becomes the focus of attention not only for him but also for the health care professionals who care for him. And the heart may continue to occupy centre stage for many individuals years after the event.

> Well if I overwork myself . . . I can tell when I overdo something. Like today I could tell. I jogged and played hockey [he attends an exercise programme for post-MI patients]. I feel tired, that I overdid it. Your whole day afterwards is sort of . . . I feel tired and will do nothing but sleep.

In retrospect, Radowski believes that he should not have jogged for twenty-five minutes before the hockey game. "That is when I probably tired myself out, before the game was started." This was not the usual workout, because that day there was an added stressor. They were playing a team from another cardiac rehabilitation programme and his

team wanted to win, so the pressure was on to perform. Radowski, however, had learned over the years to pace himself.

Like most people who undergo a crisis that changes their lives in many ways, Radowski asked the inevitable question, "Why me?" and then, "What will happen to me?"

> Most of all, I thought, "Why me?" At my age, that is what bothered me. I was thirty-eight years old when it happened. ... WouldI be able to go back to work, would my life be normal again, and would I be able to do what I like to do?

Asking the question, "Why did this happen to me?" implies the individual is aware of a personal loss (Lowen, 1978). For Radowski, his illness meant a loss of health.

He still finds it worrisome that he had a heart attack while he was still young. He feels it would have been less traumatic if he had been older. This was an illness which he associated with the elderly. Moreover, he feels that the heart attack has robbed him of at least fifteen years of his life:

> I think that is why it hurts is being so young. I think if you are older, I suppose it would not bother you as much really . . . It is probably more difficult to come out [to recover] for an older person, but I think it would not bother you as much. Because if you are 55 years old or whatever, that means I lost fifteen years. Life sort of stops. It slows you down quite a bit.

He is a young man who is living an old man's existence. He cannot keep up with the tempo of life; his pace is slower than it used to be. It has robbed him of his vitality and a way of life that he once enjoyed.

The meanings which we ascribe to events are influenced in large part by our interactions with others. Radowski believes that his feelings are shared by others: namely, that a heart attack diminishes the individual's stature as a person:

> and then I feel if you are a young man you are sort of no good for anybody. That's the way I think some people think.

So having a heart attack is like being old, and being old means that you have outlived your usefulness. But if you age normally, and there is not this accelerated aging process which the heart attack precipitates, you would have contributed over time. In your declining years, you have earned the right to be a non-contributor. Hence, you are still valued by your fellow man. But how can you gain this respect if you are young, but really old because you have had a heart attack--if you are, according to Radowski, "sort of no good for anybody"?

Radowski's belief regarding the relationship between having a heart attack and the age-related dimension is reinforced by his association with other post-MI patients. Inevitably, he is the youngest in the group: it happened in the ICU/CCU, the step-down unit, and now in the exercise programme which he attends on a regular basis.

While attending his father-in-law's funeral (he died of cancer), Radowksi suffered chest pains. This incident occurred ten months after his heart attack. At first he was concerned about the pain, but later he was embarrassed about being incapacitated in public because "people talk." He attributes this to his age; after all, a man of his age should be healthy. It was disturbing to display his limitations in a public place.

How did Radowski pass the time in the ICU/CCU? He was used to a very active life and suddenly this came to an abrupt end.

> Actually to me that time went by pretty fast when I was in the CCU. It didn't drag that much. Although I may have been given some drugs. But the first three days didn't seem long at all for one thing. And I guess I was sort of depressed.

> . . . As I started getting up, I started improving quite fast.

At first, the individual may wonder whether he will survive, and then as he sees signs of improvement, he knows he will:

> When they discontinued the intravenous and took the monitor off, that is the time that I thought I was getting better. That's the time I thought, "I am going to get out of here."

But Radowski felt better about himself before that when he was told he would be transferred to the step-down unit.

Radowski continues to look for signs of improvement; hence, he looks forward to his six-month check-up. This includes a stress test. His first stress test "wasn't good at all. I stayed on the treadmill for three or four minutes." After twelve weeks in the exercise programme he showed marked progress: he stayed on for seventeen minutes and the doctor said, "You would be able to do just about anything you want."

The exercise programme is now an integral part of his life. In addition, it provides evidence of how he is progressing:

> You have a stress test before you enter the programme, then you stay on the programme for twelve weeks. But within a couple of weeks of that programme I could see myself improving just about every week or so. So when I was up to the twelfth week mark, I knew I was going to do well on that stress test. I was feeling good.

Radowski continues to exercise regularly. He attends an exercise class for post-MI patients twice a week and exercises on his own three to four times weekly. Exercise makes him "feel good," and moreover, he has a lot of faith in what it can do for him. It is his life-saver:

> I would say it is sort of my last chance, really, if they say exercise has lots to do with it [does he mean it may prevent a re-infarction?]. That is what I want to do. But right or wrong, I don't know. I suppose it has done quite a lot to

help. But as long as a person does not overdo it.

Has exercise become a substitute for work? Once the work place provided him with the necessities of life; now the gym or the jogging track seems to be the source of life itself. But there is a difference between going to work and going to the gym. In retrospect, Radowski feels that his heart attack could have been prevented. He attributes the onset of his MI to work-related factors: to the chemical dust which filled the air and coated his body and clothing (although, he says, now the situation has improved) and to being overworked. He did not just get sick; his heart attack had to be the logical outcome of something. He had to march to someone else's tune; he could not set his own pace. Not so with his exercise programme. He sets the pace, he is attentive to his body's reactions, and he paces himself accordingly. After his workout, instead of going to the pub with the boys--which is what he often did after the job--he now has coffee or juice with his co-participants. When he returns home from his exercise class he has a rest, just as he did when he worked. Instead of a pay check for his efforts, he now feels better, his stamina and endurance increasing incrementally. Furthermore, exercise seems to be a centring experience. He is alone with his thoughts and his feelings, and the world is somewhere out there. "It seems as though you sort of forget about everything when you are doing it [exercising]. I am just happy to be doing it."

The post-MI patient may leave the hospital buoyed up by hope. Home is a celebration of life over death, but "the man who comes home is not the same man who went away" (Schoenberg and Stichman, 1974, p.

149). Radowski was easily fatigued:

> You tire easily, but it seems that you recover real fast if you lie down for a half-hour or so--your tiredness will go away. You are not tired because you need sleep. It is just that you are "played out."

At home he "laid around most of the time." Radowski, however, went for daily walks--three to four times each day. He was glad to go home, but one thing bothered him "a bit":

> When I looked outside, I saw other guys walking around, working on their lawns and gardens and stuff like that. And here, I couldn't do it. That was probably for a couple of weeks. Then I felt better and could walk further.

Returning to work, on the one hand, is indicative of recovery; but on the other, it could be fraught with anxiety-producing situations as the individual becomes aware of the fact that he is not the same man that he was before his heart attack. This is most dramatic for the worker whose job is physically demanding. Upon completion of the twelve-week exercise programme, Radowski returned to work full-time (this was six months after his heart attack). His work load was less physically demanding than before his heart attack. He worked the evening shift because "the work was easier." It also allowed him to continue in another cardiac rehabilitation exercise programme from seven to eight o'clock twice a week.

The real test of the individual's ability to perform occupational work, especially if his job is physically demanding, comes when he returns to work. Activities that were taken-for-granted may produce cardiac symptoms. For example, Radowski experienced "a sort of tightening in the chest" whenever he ran up and down the stairs. Hence, he learned by trial and error which activities to avoid and which to modi-

fy. His fellow workers, at first, observed him "quite closely"; if he had to lift heavy objects, someone would do the lifting for him. After "a month or two," it was all forgotten. "After they saw what I was capable of doing, I think they just said 'leave him alone'." Radowski was not bothered by his fellow workers' solicitous behaviour, because his doctor told him to avoid heavy lifting. "If somebody did that for me, I was glad and it did not bother me."

Radowski, however, is less tolerant of the "overprotective" behaviour of his wife and teenage daughter. Moreover, he was happy to return to work to escape their constant surveillance. When the family is unaware of the post-MI patient's capabilities, this often creates difficulties. The tension arises between the patient and family members when they treat him as though he were an infant and discipline him as though he were a child when he engages in activities, which he can manage but, which they feel are inappropriate. For Radowski, it does not happen as often now:

> because they know more or less what I can do, but before it was kind of different. You see, they did not see me workout at the gym, and they figured when I started doing something . . . they didn't think I could bend and lift. And when I started lifting something like ten to fifteen pounds, or cutting the lawn, they thought I couldn't do it.

So what happened? "They tried to do it, like cutting the lawn. They tried to cut it before I decided to cut it." He became frustrated when he saw them doing jobs "badly"; for example, they always cut the lawn too short. He knew how to do it, he could do it, why this race to thwart his plans? This overprotectiveness is still a source of frustration:

> Even now, a lot of times she [his wife] would say, "You really shouldn't shovel snow" or things like that, and I go and do it . . . but when I do something like that, I take my time. I do not rush myself.

Overprotectiveness calls into question the individual's capacity to act, it is judgemental, and can be an obstacle to the individual's desire to lead a normal life. Furthermore, it is a form of domination: it makes the other subordinate. Being overprotected reminds him that he is no longer the man he used to be--it brings his heart attack into relief in that environment.

At the time of our conversations (February, 1985), Radowski was unemployed due to the economic situation. Radowski had worked for the same company for twenty years. He had been back at work for one year when all employees with less than twenty-five years of service were terminated. Is he looking for a job?

> Well, I don't know if I am looking for a job. It is so nice not to work. No, I think I will start looking for something now. I don't really have to yet. So I am just taking it easy now. It's a year . . . but in the springtime [1985] I shall start looking.

Since Radowski has been unemployed, he no longer requires medications for hypertension. Now he wonders if it is worthwhile finding full-time employment when it appears to have detrimental effects on his health. "My health is more important than going to work, unless I can find something different . . . a job that doesn't have much stress." Although he appears to be in good health, is he haunted by fears of recurrence and of premature death? Does he intend to work again?

> Well someplace where I don't have to run around too much . . . where there is no stress. It's hard to find a job like that, but some place where you are not responsible for too much . . . maybe cutting lawns and golf courses where you are sort of on your own.

Does Radowski anticipate that his MI could jeopardize his chances of finding full-time employment?

> I think there will be a lot of trouble with that in getting a new job. Because I do not think too many outfits will hire a guy. . . . You have to have some kind of life insurance. You have to get medical clearance. I don't think they will ever look at you.

Thus, setting what seems to be unrealistic expectations for future full-time employment--a job without stress--Radowski may never have to face the reality of being told that he is unemployable because he has had a heart attack. Hence, his ego is left intact. He has found a way to protect himself.

Before his heart attack, Radowski enjoyed going out with a couple of his fellow workers. Sometimes on Saturdays they would play pool and then have a "few drinks." Now he says he has "to watch" his drinking, and because he cannot "keep up" with them, he feels "left out." Thus his relationship with his old friends is less intense; he has a tendency to withdraw and isolate himself from them. His social world has dwindled. He has become a dropout. Dropping out presupposes a way of life to which he subscribes and of which he is no longer able to partake. He suffers, not because he feels different, but because he is different. He is different not by choice but by circumstance. He is outside the dominant lifestyle. He liked dancing: polkas were his favourite, but now they are too strenuous for him--waltzes are more in keeping with his tempo. He laments, "You can't go out and go crazy. You have to pace yourself." He wanted to start curling, but he found that the "sweeping" motion caused some discomfort in his chest so he has given up trying. He is not inclined to expose himself to unneces-

sary risks.

Since his heart attack, Radowski spends more time at home. When his wife and daughter return home in the evening, he has supper ready. He even experiments with different recipes. Before his heart attack, the only time that Radowski cooked was when they went camping.

There have been many changes in his lifestyle since his heart attack. There are, however, two activities which he still enjoys--fishing and hunting. Admittedly, Radowski seems to be constantly aware of having had a heart attack. He does not feel very secure when he is far away from the city in some small town or isolated area where he feels that the medical facilities are not of the same calibre as they are in the city. His wife and his friends (the ones he goes fishing with) took "lessons on heart patients":

> A couple of my friends did that because they figure if something did happen to me at least they know a little about it.

What did he think of this gesture?

> I was kind of glad really, because it seems that it gives you more protection when you go out.

Radowski says he takes better care of himself since his heart attack:

> I think the person looks after himself much better after. I think he has to, he really doesn't have much choice. If you don't, it's going to be another one or whatever.

But, at the same time, he seems to have some lingering doubts about how effective his change in attitude and change in lifestyle are:

> Well, I guess there is nothing you can do, really. What is going to happen is going to happen. You have to look at it that way. I suppose you can worry all day and all night and that is not going to change a thing.

He does not protest his fate. What is the use? Nothing will change.

Radowski seems to live with uncertainty. He says of his six-month check-up, "You don't know if you are going to make another six months." I was curious about this statement, because he seemed to be in better physical condition now than he was before his heart attack--and this is important to him. In fact, he volunteered this information during one of our conversations. So I asked, "Do you ever think about that [in reference to whether he will make his next check-up]?" He replied, "Not really, no. Maybe in a way it is out there someplace, but you sort of try to avoid it." I countered with, "You think you might cross the street and someone will run you over?" I knew this was not what he meant, but I wanted to determine if my assumption was correct: I thought that he was really saying, "I shall eventually die from a heart attack. When? That is a matter of time."

> No, that's not it. I don't really think of that. I always do think if something is going to happen the proof is there, it is going to be your heart. That's the way I look at it.

So he thinks he will have a fatal heart attack? "Yes, that's why I think you have to look at it that way."

As we were about to terminate our conversations, I asked him, "Is there anything else that you would like to share?" He responded:

> Don't have a heart attack . . . I think that is probably the worst thing there is. Being crippled is probably the worst, because you cannot move around. But your heart is a sort of main machine, really, and if that thing gives out, you are pretty well out of commission.

Does this statement capture what life has been like for him since his heart attack--is he out of commission? Is he just going through the motions each day, doing what he has to do to stay alive?

RAYMOND SINGH

Raymond Singh immigrated to Canada in 1969. Before obtaining immigrant status, he studied at a university in Eastern Canada (on a student visa) where he met his wife. They returned to his native land (Guyana) where they were married before returning to reside in Canada. They have two children, a boy aged eleven years and a girl aged seven years.

Singh was driving home from work when he experienced chest pain. At first he "thought nothing of it," but then,

> it got worse. It went up to my shoulders, out to my arms. I didn't know whether I should stop, or just drive home . . . I just passed it off as indigestion, and went to bed.

The pain, however, was of sufficient magnitude to curtail his activity. He went to bed but the pain did not abate; in fact, the situation became worse.

> I began to vomit, and my wife said, "Why don't you go to a doctor?" They [his mother was visiting; she resides in the U.S.] talked me into going.

En route he thought this was a waste of time, that it was indigestion; however, the pain persisted but he never thought about a heart attack. It was in the emergency ward he learned that he had had a heart attack:

> And when they [the doctors] told me it was a heart attack, they said, "you know you have had a heart attack. We will have to keep you for a few days." It didn't hit me until they hooked me up to all the equipment. Then it dawned on me maybe I am really sick . . . the pains got worse.

The fact that his symptoms were taken seriously instantly, that he was attached to a monitor and examined by doctors, was not reassuring but distressing. Singh's disposition to become tense when stressed

made his situation worse:

> I guess I am a very tense person because they couldn't do much for me at the time.... It scared me because they were trying to get the pains to go away and my blood pressure to come down. [Singh was not sure if his blood pressure was elevated or low.] They said they just couldn't get anything done because the doctor said I just stiffened up.... "Just try to relax" ... my wife was there.... She talked to me and we finally got it down.... It took a couple of hours.

Learning the diagnosis and being subjected to the routine monitoring devices increased Singh's anxiety. He could not relax, and this in turn aggravated his condition; in fact, it made it more hazardous. Although Singh said, "to say I was really scared at the time, I wasn't, because I didn't realize how sick I was." What accounted for the tension? Was it the admonition to relax, that this <u>per se</u> became the focus of attention for him and the harder he tried to relax, the more he failed to do so? His tense state rather than the cardiac event became the focus of attention.

It took a while for Singh to realize, as he said, "how sick I really was." When did this happen? Three days later he woke up to find:

> three doctors, four nurses, my minister, my wife and kids at my bed side. I asked, "What's going on?" The doctor said, "Nothing, you just had a little set back." I said, "What time is it?"
>
> Someone replied, "It's noon." I normally awaken at 6 a.m. when I sleep in a strange bed.... I was out for four hours. It is then I really got scared. I guess they just revived me. I then asked the doctor, "Another one like that and I would be gone?" He said, "Well, if you do things right you won't get another one, you shouldn't...." I was scared.

What was he afraid of?

> I looked at my two little kids and I couldn't think of them

without a dad. That's what bothered me quite a bit.

If Singh had not been convinced before that he had suffered a heart attack, the second incident brought him face to face with the reality. Singh realized that he could die, and this was when he was conscious of being scared. "I really thought I could die. . . . I started getting scared." It was possible that he could even die in his sleep.

> I was asleep. I went to sleep that night, and I didn't know a thing until I woke up at noon the next day. So I didn't know what they did or what happened until a year later when Mum told me what happened.

Singh's resuscitation was uncomplicated and his recovery complete. He was to learn some three to four months later, when he had coronary arteriography, that the damage was not as extensive as it was thought to be:

> I was quite happy to have it [the angio]. I knew he was going to tell me how much damage there was. And I was also concerned about them talking about having a bypass operation. I had it [the angio] in the morning, and it was sometime in the afternoon before he [the doctor] came back and said that he had good news for me: "For a guy who went through so many problems in the hospital," (that is why I had to stay in so long,) "your heart damage is minimal." He said, "If you watch yourself and do the things you are advised to do, you shouldn't have another one."

Singh remembers feeling "very tired" and "very weak." He felt so tired he could not even shave: "I would shave half my face and I would have to rest." He asked his wife to get him an electric razor. The tired feeling was that kind of feeling that you get "when you have been working all day." He was physically tired even though he hardly exerted himself. Moreover, in the CCU he was confined to bed. Even turning the pages of a book was tiring. This feeling of fatigue continued for some time. "If I walked up the stairs, if I walked around

the house, I would get tired very quickly for the first few months."

Sleep was the antidote for this tired feeling, but he was afraid to sleep. What if he should die in his sleep? Singh was not afraid, however, to sleep while he was in the CCU "because they could see you all the time. The nurses' station was right before my eyes." He was "hooked-up" to the monitor, which would register any abnormality and sound the alarm. Moreover, he may have been experiencing what Abbott (1979) describes as "separation anxiety" (p. 192), which occurs when the patient is "unhooked" from the monitor and is transferred to the ward. Furthermore, he had proof that the system was efficient: he had been successfully resuscitated three days after his admission to the CCU. What would happen on the ward?

> After I left the CCU, when I was in the recuperative ward, when I got up there, it was the first time they allowed me to walk around and I knew I was getting close to going home. Also I was scared that if I should go to sleep I won't wake up. So I watched TV and read after the others [his roommates] were asleep. I would read until I fell asleep, usually between twelve midnight and 1:30 a.m. And strange, I never thought about it in the CCU.

When Singh became more active--that is, when he was allowed to climb the stairs, take a shower, and walk in the hallway--his fear of going to sleep was alleviated.

Singh passed the time in the CCU by reading, but as stated above he could not hold the book for very long due to fatigue. He "chatted" with his wife and his five-year-old son who visited after school. His son sat quietly by his father's bedside "all afternoon until nine or ten o'clock at night." He would bring in his books and he would talk to his father. When Singh was transferred to the ward, his son visited with his father's roommates. He even brought in his camera and took

pictures. The interaction with his son at this time created a special bond which has endured the passage of time.

It was either December 17 or 18 (he cannot remember the exact date) that Singh had his heart attack, and he was discharged on January 10. In the quiet moments there was time to think; he was preoccupied with what would happen to his children. At the time of his heart attack, he was forty-five years old and he had a young family--his son was five years old and his daughter between one and two years old. The event, occurring as it did at Christmas time, was of added significance. This is a time for family, and the Singhs are a close-knit family unit:

> I kept thinking mostly about the kids and what would happen to them when I was not there to put up the Christmas tree. . . . My daughter was born in 1977--she was a year and some. And of course she wasn't brought into the hospital for the first two weeks, but when I got upstairs they brought her in and she would have nothing to do with me. She did not recognize me at all, and that hurt.

Singh was beginning to feel that he was not being a father to his children, and his daughter's reaction must have confirmed his worst fears. He was unable to meet his own expectations of his father role. Would he be able to in the future?

After a two-week stay in the CCU, Singh was transferred to a ward, where he shared a room with three other patients. His wife and son continued to visit him daily. In the CCU his visitors were restricted to his immediate family: his wife, son, mother, and sister [who came to visit him from the United States]. Once he left the CCU he had many visitors. He was always there and available. People would visit and there would be an interchange between him and the outside world. In

addition, Singh's visitors were a source of comfort and inspiration to him. They provided him with the will to live, with the desire to survive:

> The number of people that came to see me and they were of different religious backgrounds. They all had "prayer circles"--some of them were Roman Catholics. Our baby-sitter's sister is a nun, and they were saying special prayers . . . and some of the people from the Fundamentalist Church, friends of ours, they were doing the same. All of them used to pray. Our minister came in every day. . . . I used to go to church pretty often, mostly every Sunday, but I really wasn't that attached. . . . When these people came, they really picked me up.

His illness made him realize how much people cared for him; it gave him a new outlook on life.

Singh did not choose his cardiologist; instead, he was assigned to the one who was "on call" when he was admitted. He wanted a doctor who had time for him. His expectations were not realized:

> He [the cardiologist] came in, he examined me, and he left. He never told me I was improving, getting worse, nothing, not even "Good Morning" or a smile. He would come in, pick up my arm, take my pulse, put his stethoscope on my chest and write in his book and leave. The doctor who was in charge of the Unit, he was quite nice. . . . He would come in and talk to me, ask me how I was feeling and stuff like that. . . . When I went to my cardiologist's office after discharge, he would take my blood pressure and "sound" me--no words. That's it.

The cardiologist treated him like an object, not as a human being who had feelings.

Singh did not wish to hear that he was improving when he was not. Hearing "nothing" was most distressing to him. "I knew my heart would not come back to normal, but at least he could say you are stabilizing or you are getting worse." He continued, "He didn't even tell me what my physical capacities were, whether I could push a car or shovel snow.

Nothing." Explanations can eliminate much fearful fantasy and enable the individual to create and pursue new options with confidence.

Although Singh could have voluntarily changed his cardiologist, he never did. Why not? He was forced to see another cardiologist when his original cardiologist left the city. This time he selected someone whom he had had contact with during his hospitalization. His relationship with the second cardiologist was more congenial.

Singh looked for signs of progress and for verification from his doctor:

> not that I expected my heart itself, physically, to get better. But, I expected what was left of it, with my exercises, that I can gradually increase my physical activities as well as physical work. Every time I went to the doctor, I said, "What are my physical limitations now? Is it the same as last time?" . . . We talked about things I should do and shouldn't. I advanced from the stage of doing absolutely nothing to cutting the lawn and doing the garden. Right now the only restriction is shovelling snow and lifting heavy things.

Over time, Singh's visits to his doctor's office were further and further apart. This coincided with the increase in his physical activity and his return to a normal way of life. He has not seen his cardiologist for about two and a half years. He feels there is no need to see him.

Singh spent two weeks on the ward. During that time, three of his roommates died. Death under normal circumstances evokes strong feelings of uneasiness. How did these events affect him? He did not identify with the persons who died or imagine himself to be in the same position. He found some differences to separate those who died from his own situation. One of the three he knew "quite well," but according to Singh he was seventy-five years old, and he had developed com-

plications. In addition, he had cancer. He never got to know his second roommate; he was admitted during the night, and when Singh awoke the next morning, "he was gone." His third roommate, unlike Singh, did not comply with the therapeutic plan; he smoked when he was not supposed to and he got out of bed when he was not supposed to. Moreover, Singh described him as "ornery and was looking for his problems."

Singh wished to return home to spend Christmas with his family; however, when he was unable to do so, he seemed to take it in his stride:

> Every time he came in and said, "I don't think you should go home yet," I realized it was for my good. It was better for me to stay there. I could go home and the care wasn't there. I mean my wife was there, but. . . . So I thought the longer they kept me there it was better for me. So then Christmas and New Year's came and went and it didn't bother me anymore.

His trust in the competence and in the efficiency of the health care professionals seemed to make it easier for him to comply with the therapeutic regimen. Does a prolonged hospital stay affect the individual's confidence in his ability to cope when he is discharged? Does it foster dependence on the health care professionals?

Going home brought into sharper focus the things he would not be able to do, at least not for some time. For example, Singh had his heart attack in the winter; this meant that he could not shovel snow--and that bothered him because "it would be snowing and my wife would be out there shovelling snow." Another source of frustration was grocery shopping with his wife. He used to carry the heavy shopping bags--now his wife had to carry them. This was an affront to his manhood:

> It kind of takes away from your manhood. It drops you a couple of levels down.... I go to the grocery store with

> my wife . . . and they told me not to pick those bags up, and yet she is picking those bags up and everybody is walking by and looking at me and at her. It's kind of embarrassing. So I wouldn't go to the grocery store with her.

There was a sense of weakness and emasculation over which he had no control--he was vulnerable. Singh avoided this embarrassing situation by staying at home, but did staying at home make it any easier for him to tolerate? Was he not neglecting one of his duties as father and husband? Sometimes he did accompany his wife on these shopping trips but in order to avoid an embarrassing situation he would leave her when they got to the check-out counter:

> or if I went with her, when she got to the check-out, I would just walk down the mall or something.

His physical capacity not only affected what he could do as a husband, it also affected his relationship with his children:

> The kids would want to go someplace. . . . I would be too tired. I couldn't go tobogganing and run back up the hill. So you have to go to the neighbours.

Having had a heart attack meant that he was missing out on things that were important to him:

> As a matter of fact I got quite bitter that I couldn't do physical things. I got quite edgy, and the kids suffered because no matter what they said, I was just after them.

The ones he wished to protect became the target of his disappointment and his frustration:

> I think it was because I was bitter. Not being able to function as a normal human being as far as the physical. . . . And they realized that too. They used to stay away from me as soon as they saw I was upset.

His feelings of inadequacy surfaced in other relationships too:

> Driving home once, I saw a girl that I knew. Her car had broken down, and she wanted to push it off the road. What do I tell her?

His sense of gallantry exceeded his capabilities.

Returning home was a joyous occasion, but he soon became bored. "I had time on my hands and nothing to do," even though he had company--his wife, mother, and baby daughter. He awoke sometime between seven and eight o'clock each morning, he had breakfast, read the newspaper, rested before lunch and again after lunch, then got up at about three o'clock. He lost some weight in the hospital, and physically he felt "quite good." He admitted, however, that he was "scared to move, or to pick up anything heavy." Lifting heavy objects was prohibited in any case. His mother had a tendency to "fuss" over him:

> If I wanted a pencil and I got up to go for it, she would say, "What do you want? I will bring it for you." . . . If I just breathed hard, she would say, "What do you want?"

He responded to her concern by saying, "Hey, Mom, just cool it. I am not an invalid, I need exercise."

During these trying times, Singh's wife was a pillar of strength. He discovered qualities in her that he was not aware of before:

> I really got to admire her. She really stood up through this thing like I don't know. She must be really strong, to look after those two kids and to look after me. As a matter of fact, she was studying for an exam. . . . She phoned the prof, told him what had happened, and he told her that the exam could be deferred. So that helped. . . . Two weeks after, she was substitute teaching. About a month after, she got a full-time job. So she looked after the kids and she looked after the job.

Although Singh said that they had had a good marriage before his heart attack, that they were family-oriented, he felt that there was no guarantee that the marriage would survive his heart attack. His heart attack could be the beginning of the end of their marriage. He said, "Someone else may have walked out on me." In other words, the crisis

could have brought the marriage to the breaking point.

Four months after his heart attack, Singh returned to work. This was a major boost to his morale. "It marks a stage of improvement in your mind whether it is so or not. If I go back to work, I am not sick any more." At first, he worked half-days until he felt tired, and then he went home. He avoided the stress of rush hour traffic; he got to work at eight o'clock instead of seven-thirty, and left at one o'clock when everyone was back at work. Going back to work was a welcome occasion; "it broke the monotony" of being at home. Is it possible that it also meant that he was on his way to resuming a normal way of life?

Before his heart attack, Singh's work place was mainly outdoors; for two years after his heart attack, he switched to an indoor locale. Later he returned to the outdoor site but in a different capacity--as a supervisor. He is a surveyor.

How did his colleagues treat him when he returned to work?

> There was one guy at work who came to see me every day when I was in the hospital. He is a close friend of mine. The rest of the people, I don't think it mattered to them. It is just another guy. Another heart attack, so what? Like the day I went back to work, people didn't rush up to say, "Hey, welcome back Raymond, nice to see you again." They just walked by my office as though it was a regular day.

This was not a regular day for Singh. This was an important day in his life: he had survived a heart attack, he had escaped being an invalid, and now he had returned to work. Maybe his co-workers' reactions could be expected. He was now in a different situation. The people that he was close to did not work indoors. They worked outdoors:

I was close to the guys out in the field, but I guess they

> couldn't get in. But with the people in my office it was just a casual basis. We were not say like friends who socialize together.

In the work situation, Singh could manage without assistance from others. His work was not physically demanding. There was, however, one lady who checked on him from time to time:

> She always poked her head in my office to see if I was okay. She didn't tell me why, but she would come in and ask me, "Are you okay?" Sometimes I would sit back when I was tired. . . . She made sure she came in to check.

This lady's concern, rather than being a source of frustration, demonstrated a caring attitude. Moreover, it was in keeping with her personality; her behaviour was natural rather than forced. She was not doing it because she felt obligated to do so. She was doing what came naturally to her:

> Well, she is the motherly type. She has a couple of kids about thirteen and fifteen years old. . . . Our kids have the same interests. My little boy likes playing hockey, so we talk quite a bit. So she sort of . . . well, I was much closer to her than to the other employees.

After four months, Singh resumed work on a full-time basis. He continued to work indoors, however, and to avoid the rush hour traffic--he left his downtown office at four o'clock instead of four-thirty. By being aware of stress-producing situations, he was able to take action to circumvent them. He had been working for the company for eight years, and job security was not an issue. Going back to work was therapeutic:

> After I started working, I got my confidence back. And after I got over that period of being bitter, things were just about back to normal. Except I still don't do certain things. . . I used the snow blower, I wouldn't go pushing snow.

It is not only people who have had a heart attack who use a snow

blower, many "healthy" people do, so using it does not single the individual out. If anything, use of a snow blower may be a sign of affluence, of success. The individual could afford this luxury.

The post-MI patient is often counselled to make a number of life-style changes. Not so for Singh:

> They really didn't suggest anything except not overdoing physical things. He told me, "If you have a flat tire just leave it there. Don't jack the car up." But I have been doing that now.

The doctor did suggest, however, that he walk on a regular basis. It was winter time, so he began his daily walks in his basement; but, unable to reach his target heart rate, and with his doctor's permission, he began jogging. Singh was on his own as far as his exercise programme was concerned:

> He just told me, "Get your heart rate up to one hundred and twenty per minute and keep it there for twenty minutes." I would walk and jog.

Starting a programme of physical conditioning at home can have important repercussions for the patient's well-being, as it raises self-esteem, builds confidence, and fosters independence.

Singh was on Isodil for three years. He took his medicine as prescribed. The doctor also prescribed Valium. He was told to take one every night:

> I took it for about three or four nights, then I found that I didn't need it to go to bed. . . . So I asked him, "Do I still need the Valium?" and he said, "If you can go to bed without it, don't take it."

Like most post-MI patients, Singh became depressed. His depression started when he returned to work:

> I would sit there and just stare into space. . . . I was de-

> pressed; it goes right back to the physical thing that bothered me most. I would get depressed not being able to do the garden. At the office, if at any moment I had no work to do and I had time to just think, then I got depressed.

Work was the antidote for his depression. Time to think triggered the depression; when he was occupied, there was no time to get depressed. His bouts of depression occurred over "a couple of years." In addition, "every December it happens." The December episodes last "about a week." December is the anniversary of his heart attack. Is the depression related to the myth that "recurrence is apt to take place around the first anniversary" (Hackett and Cassem, 1979, p. 211)? Singh's depressive bouts, however, continued beyond the first anniversary. He described the experience of being depressed in the following way:

> I feel sorry for myself, but not continuously. I might be depressed for half an hour, an hour. Then I would probably go outside with the kids to a friend's house, then that's it. And it may not happen again for another week. But to say depressed twenty-four hours a day, seven days a week, no.

Singh did not consult a doctor about his depression--it was self-diagnosed. He did not think it was "serious enough." It did not interfere with his daily tasks, and he could function at the prescribed level. When he became depressed at home, his son would "put something" in front of his face and say," 'Dad, what are you thinking about?' Actually, I found that is how I would come out of it at home." The first year was the worst:

> It just happened; it was still on my mind. Now I seldom think about it. Since the last time I was here [refers to our first meeting] I haven't even thought about it. I must admit it is still on your mind and you wonder if you will ever reach the stage where you will be a normal person as far as the physical.

What is it to be a normal person?

> Doing the things I enjoy doing, I like sports, I like playing soccer with the kids, racquetball and tennis. All that was out, and I am a physical person, and I wouldn't be enjoying myself if I couldn't do those things.

At the point of hospital discharge and for sometime after, there were a number of restraints. He could not do what he wanted to do; instead, he followed the doctor's orders. Did this represent a loss of control?

> You haven't lost control. . . . The doctor is the professional in the field and he tells you, "You don't do that." For three or four months you are thinking about how serious this thing could have been. . . . It is just like a mechanic fixing a car.

So the body is like a car: it breaks down, and like a car, you entrust it to the experts who know how to "fix it." It is not a question of loss of control. It is a question of who has the expertise to remedy the problem. For a car, it is the mechanic; for the body, it is the doctor. Since you have faith in the experts, you follow their advice. Singh did just that, and now he is able to do all the things he wanted to do. He is living a normal life.

When did Singh become more optimistic about his situation?

> One of the turning points was when I went back a month later for the angio and he [the doctor] told me that there wasn't the damage he thought there was and that I wouldn't need a bypass. "Nothing, if you watch what you do." . . . The second year things started looking pretty bright.

The fifth anniversary of his heart attack was another important milestone. He believed that if he survived five years that his chances of having another heart attack were greatly reduced. Instead of being depressed for one week, on his sixth anniversary he was depressed for one day--THE DAY.

Is Singh able to do whatever he wishes to do? Are there any limitations? The last time he had a check-up, which was three years ago, he was told to avoid lifting heavy objects, such as a desk. Now he disregards that suggestion. Initially, Singh adhered to the medical prescription. Now he decides what he will and what he will not do, even if it is in conflict with the doctor's recommendations. Why? He appraises his capacity to perform various physical activities before carrying out those activities. Does he feel that he "knows" what he can do, and has he learned to trust his innermost feelings more so than externally imposed sanctions? He even shovels snow, which is against his doctor's orders; in spite of his wife's protestations, he engages in this activity:

> But sometimes, as I said, I still even go out and shovel snow, and my wife gets mad at me. If I get tired doing that I come in. . . . If it is too cold, I won't do it.

He does not engage in any stressful physical activity before assessing the situation, and he has learned to pace himself and to be attentive to and to respond to the "signals" which his body emits. He said, "I shovel snow because I feel I can do it." He is aware of the effects of shovelling snow on his body, and he knows that he is pushing his limits when he engages in this activity. Does he have to prove to himself over and over again that he can do it?

> Every time it snows I go out there [we laughed]. I wouldn't do the whole job. . . . They [his wife and his son] are more upset than I am. If I have been going for ten to fifteen minutes my son would come out and say, "Aren't you tired, Dad? Can I bring you a beer?" He knows if he brings me a beer I would have to sit down.

Does he ever forget that he has had a heart attack?

> Well, you never can. It's there in your mind. You could never forget it, 'cause you know you have had it. I never think about it for weeks on end. I will go to work and come home, go on holidays, and I don't think about it.

His wife and his son seem to monitor his physical activities, not only when he is shovelling snow but also when he works in the yard. How can he forget?

> My son and my wife, if I go out to cut the lawn, they keep an eye on me. . . . If I start digging or spading the garden, she won't let me do the whole thing in a day "I think you have had enough."

Furthermore, how can he forget when he is surrounded by stories of persons who have had a heart attack?

> You know it's something you read about in the paper, a man dies of a heart attack; you look at TV and there is a show. In some of these shows people have heart attacks. You just can't block it right out. . . . Well, you remember, I was in that position once. It doesn't get me depressed or scared or anything.

Is he reminded by others (excluding his family)?

> No,not really. It is only . . . it's funny . . . people who have pain or something in my office they come and say, "Hey, Raymond, what is a heart attack like?" They know it doesn't bother me to talk about it.

His heart attack has made him an "expert." He has had the experience, others consult him, because they know that he knows. Thus, in a peculiar way, it confers status on him.

It is not uncommon for persons who have had a heart attack to try to determine the cause. Singh was no exception:

> I tried to figure it out. There were two things. One of the main things, I was supervising a project. It was a pipeline from ---- to Edmonton. I was the only supervisor on the project. I had about ten crew, I had a deadline coming up, I had about four months left, and I was working long hours and weekends--Saturdays, Sundays, hardly getting home. And a few months after the project was finished, I had a heart attack. I figured it could be the pressure of that job, or I was a

> bit overweight too. There is no history of heart attacks in my family.

Perhaps by identifying the job-related stress as a source, this "decreases feelings of self-blame and externalizes the cause" (Rudy, 1981, p. 355). He was a victim of circumstances. Singh decided, however, to reduce these two risk factors: he lost thirty pounds, and he eventually changed to a less demanding job. After his heart attack, he worked for another three years with the company; but as the pressure began building again as "things were returning to normal," he decided to quit:

> I decided, what the heck. My house is almost paid for, my wife has a good job, why go into a high pressure job any more?

He and a colleague started a business venture, but the timing was bad and they "never made it." They decided to liquidate and once again to seek employment with a company. He wished to find a position "two stages below" where he was; this proved to be a problem. Prospective employers were suspicious. He said, "They figured I was just trying to get something to hang onto until a senior position came up," and he could not convince them otherwise:

> I don't want a high-pressure job because I can have another heart attack, and the only way I can stay in my field is to move two steps down because I am not trained for anything else.

Before his heart attack, Singh said:

> I used to take my work home with me. I would come home for supper, and then drive back to the work site and have a look to see if everything fitted . . . and I had phone calls all hours of the night from the field crew.

Now:

> I put in my eight hours and go home. If there are any problems, they are not mine. Now my weekends are mine.

Having a heart attack has changed his priorities. He has no desire to be "a director, a supervisor, or anything like that. I am quite happy to stay as I am." He has slowed the pace down as far as work is concerned; consequently, he has more time for his family. He plays soccer, racquetball, and jogs with his son. He spends most of his time "running around with the kids." He chauffeurs his children to their activities. In the winter, there is hockey and speed skating for his son, and gymnastics and Brownie meetings for his daughter. He stays to watch his son play hockey in the winter and soccer in the summer. Moreover, in the summer, he travels on weekends with his son's soccer team whenever they go out of town or out of province. Through involvement in his children's activities, he has made many contacts with people in his community. One of the major changes which his heart attack triggered was his orientation to work and family; before, he was work-oriented; after, his family became central to his everyday life activities.

RANDALL WOYTOWICH

When Randall Woytowich had his heart attack, he felt he had been singled out by fate, and this disturbed him:

> The greatest shock was the idea that I had it, not the pain or the discomfort that it caused me but to be singled out to have this heart attack. That is what affected me more than anything else. It made me feel that I was different from everybody else. . . . It was a hell of a shock. . . . I figured here I am, I am going to be absolutely separate from everybody else, because I am going to need all this special care and all that. I would say it was the biggest single event of my life.

Reluctantly, he would become the centre of attention, attention which was not bestowed on him because of some great accomplishment but because of a failing--a deficiency in vitality and life force. What had he done to deserve this fate? Nothing that he could remember:

> Why should it be me? I figured that I hadn't done anything healthwise or physically that I should be picked for a heart attack. And that seemed to be the biggest thing and the immediate effect was the fear of the things you would not be able to do.

His heart attack struck quickly and unexpectedly; the course and the outcome remained unfathomable to him. In the quiet moments there was time to ponder his situation. Immediately he began to wonder about the future. What could he expect? The future was uncertain. He did not think about the things he would be able to do; on the contrary, his mind was filled with thoughts about things, he believed, that he would not be able to do again:

> throw ball, play baseball with the kids, pick up the kids, do a little work around the house. Immediately it goes through your mind that these are things you are going to have to forget, you won't be able to do; and yet to me, they were the greatest part of my life.

He would survive, but survival would exact a price, a very high price. Surviving is not living. Living is doing what he wants to do and doing what he enjoys, surviving is existing in a dormant state. Survival raised the prospect of a long and perhaps permanent invalidism; he seemed to have been confronted more relentlessly by his feelings of being an invalid than by his fear of dying. It would change his interactions with others and his surroundings. He would be changed too:

> As soon as I recovered from the heart attack, I thought, I

> will have to give this up and I will have to give that up. And I will have to give something else up. I think that time was one of the biggest adjustments, the fear of how I will be restricted if and when I recover enough to go home. But at no time did I actually fear for my life or fear that I would not recover. It was just the fact that I was worried that I would recover and I would miss all these things. I wouldn't be able to go fishing, . . . hunting, I would be restricted . . . not even to drive the car because that was one of the first things the doctor told me; "You won't be driving the car for awhile." . . . These are the things that are more or less your lifestyle, and you lie in bed and you have a hell of a time thinking about it. And you think about all the things you are not going to do. . . . The more you think about it, the worse it gets, because you imagine yourself a sort of vegetable.
>
> Being in the hospital those first few days, not knowing how you are going to come out . . . it never really occurred to me that I wouldn't come out, but the thing was to know how you would come out.

Woytowich's belief, however, that he might be on his way to becoming an invalid, was not in accord with the way he was treated by the health care professionals, especially the nurses. They tended to treat him like an "ordinary patient" and not like someone who was very ill. Thus the nurses' behaviour became a measure for sensing how sick he was; his sense of well-being rested on the nurses' good humour:

> They would come and joke with you in the same way as they would with an ordinary patient, and they would kid you. They would . . . give you the impression, hell these people don't think I am all that sick. When a nurse comes around and babies you and everything else, you get the impression that they are looking out for you. But when they have a more or less careless attitude towards you, you get the impression, "I can't be very sick because they are not looking after me." . . . But when they come out and they let you know that they are treating you the same as anybody else, you begin to realize maybe I am not as sick as the other guy.

Moreover, the nurses' "careless" attitude was reassuring, but would this happen if they had not demonstrated their competence and established a caring milieu?

> In fact I felt good about it [the nurses' attitude]. It made me think I can't be that sick because if I were that sick they wouldn't treat me like this. . . . A person who was very ill got special treatment. But they sort of treated me like one of the guys. It was very reassuring. I think in fact that they treated you as though there wasn't much wrong with you. And maybe as far as I am concerned it worked, because I still don't think there is that much wrong with me.

Hence, Woytowich's initial reaction and the fears he had about his future were not supported by the way in which the nurses treated him; and instead of getting deeper and deeper into the quicksand of self-pity, he began to see the light at the end of the tunnel. In fact, his self-confidence increased by leaps and bounds, and it was necessary for the health care professionals to set some limits:

> By the time I was ready to go home, they had to tell me not to do things. . . . I figured that by that time I was well enough that I could do pretty well anything.

In spite of being told what he could do and what he should avoid doing, Woytowich learned by trial and error. If he overstepped his mark he got angina (chest pain); he did not require the doctor to tell him that he had gone beyond his limits. His body revolted; it was an impediment to his projects:

> You are not supposed to shovel snow, to swing an axe. . . . Then you do it and it doesn't take long before you learn that you are not supposed to do these things.
>
> You pick up something and you get the angina, and you are warned right away. It's funny how fast you learn. They tell you in the hospital not to lift anything more than ten pounds. For an ordinary person, it's almost impossible--you are going to pick up a kid, or a shopping bag, or something like that. And you feel sharp chest pain, and you drop it and take a nitro, walk away from it for a few minutes and you are okay. . . . So you learn pretty quick you are not going to pick this up, you are not going to do that, or you do it very carefully and slowly. And test yourself all the time. You are always checking to see how much you can do and how much you can't.

To lift ten pounds is "nothing" for an "ordinary person," but after a heart attack, one is no longer an ordinary person. This transition from ordinary person to being no longer ordinary is sudden and dramatic.

What were the circumstances surrounding Woytowich's transition from an ordinary person to a person who has a heart condition? Woytowich sustained his MI in June, 1982. Seven months later--January 10, 1983--he had a coronary bypass operation. (For the purpose of this study, Woytowich's story will stress the details of his experiences up to the time of his surgery.) Woytowich's son was getting married; following the church ceremony there would be a lawn party at the Woytowich home. The lawn had a few "burnt out" patches so Woytowich had "worked very hard" that Sunday morning re-sodding the affected areas:

> I found it a heck of a lot more work than I had anticipated. . . . It was a very hard job. . . . I started about nine o'clock and worked until two in the afternoon. And that was hot, very hot. I worked real hard, harder than I usually do. I don't know why but I felt very tired. I sat down--we have a little patio in the back--and I sat down there and I fell asleep. . . . My children had never seen me sleep on a Sunday afternoon. . . . My son came over and ribbed me. He said, "What the heck are you doing? I didn't think you could sleep on a Sunday afternoon."

Later that day there was a family get-together to celebrate one of the children's birthdays. They had a barbecue in the backyard, at which time Woytowich "blacked out" for a split second:

> I just stood there and everything went black. I didn't say anything to anybody, nobody noticed it. I walked over, served up my steak or hamburger, whichever it was. I ate it, and I just didn't feel right. . . . I wasn't really sick, but something was amiss.

At about eight o'clock one of his neighbours visited and suggested

that they go for a walk, something they often did. At first Woytowich declined, but his neighbour insisted so both couples went for a walk. The wives walked ahead; their husbands trailed behind:

> We were walking along, then we crossed the street and I just didn't feel too good. I was nauseated: my head wasn't just right; my eyes wasn't just right. I just felt "punk." I told him. ". . . You go ahead, I will go back . . . I just don't feel good." "Ah, hell," he said, "come on, if we walk slowly you will be all right. . . ." I walked another ten steps. . . . I just collapsed and fell onto the ground. . . . When I woke up, the women were already back. . . . I must have passed right out, maybe for minutes. I don't remember how long it was.
>
> I just felt real weak. I just felt I would sit next to the fence. I got up and just rolled over. I must have passed out again. . . . The next thing I can remember was the doctor telling me (we were right in front of a doctor's house—he is a friend, his wife is related to my wife), "You had a heart attack. Get down to the Duggan Hospital as fast as you can." . . . By this time, the neighbour got her car, they put me in the back of the car and that is when I got the pain. Up till then I didn't remember any pain. . . . It was a pain that you don't forget . . . a closed-in pain. . . . Like a boiler built up in you, you know darn well if you burst it you would feel better. I felt all the time if I could only grab hold and tear it open and let some air in, I would be all right. . . . It was just like that. It's hard to describe.

There were some aspects of the experience for which the inadequacy of language presented the greatest obstacle to communicating what the experience was like. He continued, however:

> Like when you really want something but you can't get at it. And that is just the way I felt. If I could just tear it open and let the air in. The big thing seemed to be the lack of air. And the chest was very painful. . . .
>
> They got me down to the hospital and when they mentioned heart attack and right away the nurses and the doctors got into the examining room and they started working on me, and they took my blood pressure, attached me to the monitor.

The fact that as they mentioned "heart attack" his condition was instantly taken seriously and that he was attached to a monitor, examined

by a doctor and tended by nurses, he began to entertain the possibility that he could have had a heart attack.

> I had thought [when he was told by the doctor who first saw him and told him that he had had a heart attack] at the split second, it's impossible. That's just the impression I had. It's impossible. He must be wrong. And it wasn't until I got into the hospital and the CCU and everything else that I convinced myself that I had a heart attack. . . . I had to tell myself that I had a heart attack.

The doctor had told him that he had had a heart attack, but it was not until he told himself he had had one that the situation was real for him. This convincing took time. "I convinced myself about two to three days after I had it, when I was in the hospital and when they let me get up and walk around."

> That was a very odd sensation. I think that is the closest I can come to saying that I was given a reprieve. Like if you were going to die and you were given a reprieve was when they let me get back up on my feet. . . . That was the biggest time when the doctor said you can get back on your own. And I got up and I realized I was able to stand, and I was able to walk. . . . When I got up, I knew that I was fairly well, everything moved.

Moreover, Woytowich did admit that he feared he would not be able to walk again, and being immobilized for two to three days in the CCU may have reinforced his fear:

> Like the two or three days that I was in the CCU, that was my big concern, that maybe I would never get up and walk again. I never even thought--the idea of dying never occurred to me. It was the farthest thing from my mind, but the idea of not being able to get up out of that bed was the scariest sensation that I had . . . I thought, "Suppose I have a heart attack or something like that." The actual idea of getting a relapse and getting a stroke and being bed-ridden was a fear because that is something in my whole life that I would hate more than anything else. It was a funny sensation when you lie there and you are not supposed to move your arms, not supposed to move your legs, and not supposed to do anything, and the nurse stands by you to make sure that you don't. And you think I am not moving, maybe I won't be able to. . . .

> When the doctor came and said, "You can try getting up," it was as much as saying, "I think you can live."

Thus bed rest, which was meant to reduce the strain on the heart so as to facilitate the healing process, instead of being a positive force became a stressor. Being able to get up and walk meant that life would continue. The doctor's pronouncement seemed to have the same impact that a judge's would on a prisoner in the dock who is found not guilty of the crime. Although the circumstances are different, they have a common element--a second chance.

Woytowich's next concern was his physical activity levels. He had a tendency to dwell upon what he would not be able to do. Is this facilitated by the health care professionals' emphasis on the "DON'TS"?

> Once you realize you were able to walk, that you were over the hump, then you start thinking, "What am I going to do?" And it is hard to be able to tell yourself, "Oh, I can do many things," when you have so many limitations. What the heck can you do? You had to concern yourself about your limitations. If I go home, what the hell am I going to do all day if I can't drive the car? What the hell am I going to do all day if I can't dig in the garden, if I can't cut the grass? This was summertime--actually, the middle of June. What's going to happen if I can't do this, if I can't do that? Am I going to sit in the house all the bloody day and look at the four walls?

Each concern had its time and place; in the CCU it related to walking again; in the ward, to his limitations. How did Woytowich experience the CCU? "It was like WAITING for something. You lie there and just wait." What was he waiting for? "I am not patient usually for this sort of waiting around to get a little better. You wait to get better. When am I going to get better?" Who can answer this question? There is so much uncertainty attached to this waiting. The minutes, the hours pass and he travels with them, but where is he

going? Where will it end? Everything comes to an end. How will this situation end? Eventually he will leave the CCU. One path leads to the mortuary, the other to the ward. Woytowich was fortunate; he travelled along the latter path. The waiting, nevertheless, was tedious:

> The time drags because you can't do anything. You can't even read properly. Your mind doesn't seem to work properly all the time. Maybe your eyes are not focusing quite right. You just more or less lie there and wait. Time gets pretty long at that time.

Having visitors helped him to pass the time in the CCU. He could not interact with other patients because they were in separate cubicles. Sometimes he would "chat" with the nurses. On the ward he shared a room with three others. There they engaged in "social chit chat." They rarely talked about their predicament, although talk about the heart attack often served to initiate the interaction and to establish a "we are all in the same boat" feeling. There was no need to talk about it again and again. Their experiences were similar in many ways, and there was this "silent partnership." Woytowich, however, distanced himself from the experience. It seemed as though he was a spectator rather than the person who had had the heart attack:

> The whole thing happened. I have been through it, but I don't think it happened to me. I still don't. I still feel that way. . . . It's a funny feeling in a sense; maybe that is the reason I don't talk about it.

He created a distance between his mind and his body.

The waiting is not limited to the in-hospital experience; it begins in the hospital but it can continue for several weeks. It seems as though the individual is always waiting for "something." In the

immediate post-hospital period, it is usually test results which are done to assess the extent of the myocardial damage and dysfunction. First one test, then another, and maybe another, each one separated by what seems to be an interminable length of time:

> You go home and they tell you to come back two weeks later for a stress test. They tell you three or four weeks later to come back for an angio. You go back and you do that and they tell you three to four weeks later to come back for something else. That in-between time to me is the killer, because you are sort of waiting. You can't go anywhere, you can't do anything physically, and you can't plan anything because you don't know what kind of shape you are in. . . . That waiting, it stretches. Three weeks doesn't sound very long, and this uncertainty all the time. . . . For awhile, you have to treat yourself almost like an invalid. . . . But the WAITING, that uncertainty while you are waiting. That's the killer.

After his introduction to the sophisticated medical technology which started in the CCU, Woytowich began to trust his feelings less and less and to place more faith in the test results. He needed to <u>know</u> rather than to feel:

> You come not to trust yourself anymore. You don't trust your feelings anymore. . . . After you have had that initial attack those machines are your gods [he laughed]. The machines they have nowadays they are so foolproof in a sense in everything. . . . When you take an angio, it will tell you exactly everything about the veins [<u>sic</u>] that are plugged, which ones are working and which are not. You look at the angio and you know a heck of a lot more about yourself than what you feel. Your heart, half of it may be dead . . . but you don't know that. There is no way that you know it except that when <u>you go to do</u> something you find that you haven't got the strength to do it.
>
> So the only way you can find out how much strength you are supposed to have is to look at the angio. . . . It gives you more information. . . . By knowing the extent of your damage, you have some control over what you will do.

The angio makes the body "transparent." It permits one to see inside, to become transparent to oneself and to the health care professionals.

It presents the cold, hard facts. How one feels is subject to one's emotions and to a host of circumstances; hence, fluctuations are inevitable. The technology is "infallible" and it negates the guessing games, but the cold, hard facts may stifle hope. At least with the uncertainty you could still hope that with time the situation would improve.

Not knowing was frustrating, but "even knowing sometimes is as frustrating as hell."

> At first it was the uncertainty of the feeling before I had all those tests. And after I had the tests it was almost as bad, in fact it was worse, because then you knew you couldn't do it. You would get up to do something and you would remember you only had a small percentage of your normal activity left, that there was no way you could do it.

Could knowing facilitate becoming an invalid? Before he knew, he would attempt the activity, and maybe he would even succeed; now he did not even try.

Returning home was "pretty rough." First, he was now on familiar territory, but most of the activity which he associated with being there had to be curtailed. Second, there were some activities which he could engage in, but could he convince the people around him of his capabilities? It was difficult to do:

> It takes quite awhile to educate the people around you that you don't want extras, you don't want somebody saying, "Don't lift that because you had a heart attack, because you are not supposed to." Do anything, but don't say it, because when you hear that it bothers you. If you are going to push something or lift something and somebody steps ahead of you and pushes it away, you don't mind. But if somebody says you are not to, it bugs you.

Woytowich would not have been offended if the people around him had sensed when he needed help, and what kind, and then proceeded to assist

him. What offended him was when they made an issue of his incapacities. Tolerating his ability for limited physical exertion might have been easier for him to endure than being subjected to this belittling, condescending attitude. He became "cranky," and he had to find a way to cope with these situations:

> You have to educate yourself, you don't get cranky about these things. . . . So in that sense you learn a helluva lot of self-control through the whole situation.

Does having a heart attack put the individual on the road to martyrdom? Does self-control mean that he assumes a passive role? This could be self-defeating, because enforced passivity is very stressful for some.

Admittedly, Woytowich was to learn a few weeks after discharge from hospital that there was an underlying physiological reason for his weakness, but sometimes it was difficult to separate the real physical limitations from not wanting to do anything. Woytowich had to make a concerted effort to get dressed in the morning. It is easy under certain circumstances to neglect one's physical appearance, and this in turn affects how the individual feels about himself and what he does:

> If you don't shave one day, "Ah, to hell, maybe I shall tomorrow." Tomorrow you figure, "Ah, maybe I will let it go." First thing you know you have a grizzly beard. You just neglect yourself. First of all you neglect your clothes, then yourself, and then you just get worse and worse.

Thus the tiredness becomes the excuse for "letting oneself go." In order to avoid this, Woytowich got up each morning and got dressed.

At first Woytowich learned by trial and error which activities he could tolerate:

> Whatever you can do, you do more of it. If you find you can walk pretty good without getting angina and without puffing . . . you walk more.

Convincing his wife, however, that there were certain things he could do was a frustrating experience:

> I used to get so frustrated . . . because I would catch her doing things for me, doing things she wasn't supposed to do that I figured I should really do myself, and I had a helluva time getting that across to her that I do this, not you. As time went by you kind of get accustomed to it.

Why did his wife persist in doing what he was supposed to do?

> Then you say, "What the hell is going on here?" Well she can't come out and say, "You had a heart attack. You might drop dead, so at least I have to know what I am doing." But at one time she actually came out and said that.
>
> I did a lot of thinking on that. . . . I had the impression that . . . she knew I was going to kick off, maybe the doctor told her something he didn't tell me, or something like that.

Thus his wife's reaction created tension and suspicion in the relationship and he did not know how to respond. Did he eventually confront her?

> I did. There were times when I got crankier and worked up and I said, "What the hell, did the doctor tell you that I was going to die?" "No," she replied. Then we would hash it out, and we would come to maybe a half-decent conclusion. But originally when you saw that, it's quite a feeling to know that you are going to be left aside and the world can carry on without you.

Hence, his wife's behaviour was a reminder to him that he could die without warning and that she was preparing for this possibility.

Woytowich was very restricted in what he could do, his heart's capacity had been severely diminished. "That is why they [the doctors] were so anxious to get the bypass done." He could not even walk from the house to the garage (which was adjacent to the house) without taking a rest:

> It is a very difficult thing to adjust to the fact that you

> can't do it, that you are not as strong as you were before. . . . You are a different person.

In spite of his very limited physical capacity, six months later Woytowich returned to work--a month or two after he had open-heart surgery. He worked three to four hours per day. Going back to work was a great morale booster; it made him feel "great." He also felt "useful again." What did he accomplish at work? "I might not have been able to do it as good, but I could still do it." He was able to prove to himself that he was still capable of doing what he did before; admittedly, not at the same level, but he would temper his job to his energy level. Moreover, being back at work meant that he was no longer a "dropout"--he was back in the mainstream of life:

> One of the big things in a person getting sick, I think, is the fact that he drops out of all that. You drop out with your buddies, you drop out with your work crew and you drop away from your job. And unless you are fully retired you got to tell yourself, you keep wondering, will I ever go back? Will I be able to go back? . . . You got that feeling in the back of your mind: when am I going to go back? Will I be able to handle the job if I go back?

Self-doubt became a major preoccupation. He wished to return to work but at the same time he had doubts as to whether he would be able to function. He was out of sync with his co-workers; he did not fit. He marched to a different beat. His concerns differed from theirs. He knew that his condition would not improve without surgery. He hoped this would give him a new lease on life.

Woytowich's physical condition, whilst it may have stabilized, did not improve:

> I couldn't tie my shoes hardly sometimes. You figure you are going to step out . . . to the garage. You feel real good when you start. When you get half way to the garage you are just beat. You have no strength whatsoever. I used to get

> on the bus to go to work. The bus stop is two blocks away from the office building. I would get there on a fall morning [that was before he had his surgery], get off the bus, feel real good, walk half a block, and I would have to lean up against the wall because I couldn't walk anymore. . . . If I push it, I would get chest pain. But first of all I would get very tired. . . . By the time you get to the office you were so tired, so darn beat, you couldn't do anything.

Woytowich was overwhelmed by fatigue. His body screamed, "It's time to take a rest." His resolve generally surpassed his abilities. His mind spurred him on.

Before returning to work. Woytowich passed the time by watching his favourite television programmes--he was determined, however, that he would be selective in what he viewed and that he would not become a television addict.

Woytowich had smoked for years. He smoked cigarettes for twenty to twenty-five years, cigars for five, then he switched from cigars to a pipe. "The pipe was in my mouth when I had the heart attack." He has not smoked since, although he was quite defiant when the doctor said he would not need his pipe again. His response was, "To hell with you." The occurrence of an MI is a strong motivator to encourage the patient to quit smoking. The dietary changes were less drastic; Woytowich's son is a diabetic, so he and his wife had been following a diabetic diet for about ten years. Only a few changes were required.

Woytowich works for a collection agency. He never resumed full-time work even after his surgery. His doctor cautioned him to avoid getting tired and advised him "to pack-up and leave" whenever he felt tired. He has complied with this suggestion. Moreover, his attitude towards his interactions and his way of responding to his clients has changed. He has changed from confrontation to negotiation, from being

impatient to being less so, and from an adversarial position to a give-and-take one. Instead of pushing an issue to the limits and creating an explosive situation, he terminates the interaction when an impasse develops and lets the client know that he will call again. In this way he remains in control of the situation and of himself.

In the interval between his heart attack and his surgery, he enrolled in a cardiac exercise programme, as prescribed by his doctor. This experience had many tense moments:

> It was scary. . . . They had me on a very light programme. Like walking on the treadmill, . . . just barely enough to keep me moving. The only reason they put me on that was to keep me from deteriorating too much before the operation . . . I would go in some mornings, I was monitored all the time. I would be five minutes into the walk and the thing would jump all over [the ECG]. They would take off the monitor and put me to sit down. . . . In fact a couple of times they took me right from there into emergency. It got that serious. . . . You would come in one day, your blood pressure would be way up. The next day it would be way down. You never knew what the hell to expect. That was one of the main reasons I was so anxious to get the surgery done as fast as possible. It was the uncertainty of the thing.

Participating in the exercise programme was like walking a tight-rope; it was living dangerously and in a way it was a kind of adventure. But it was mandatory. "You do it for survival. In the back of your mind survival is the thing." Without the exercise programme, his condition could have deteriorated further; and the risk associated with open-heart surgery would increase even more. He never knew if he would return home after the exercise programme or if he would be admitted to the hospital. If the latter happened, he would phone his wife and say, "I am back in the hospital." She would respond, "I thought you went to exercise." It was not only Woytowich's will to live but also his sense

of humour which seemed to sustain him during these very stressful moments.

In spite of his decreased tolerance for exertion, Woytowich was able to drive his car. His doctor advised him to avoid stress producing situations: "Just don't get yourself into situations where you get all worked up and cranky." Being able to drive increased his sense of freedom:

> It gives you a great feeling to get back behind the wheel. . . . From then on I was able to go wherever I felt like going.

The car became an extension of his legs and permitted him to travel distances that would have been impossible under his own steam. He could not even walk half a block without stopping to rest.

Woytowich is often reminded that he has had a heart attack by the way people relate to him, by what they say, and by what they do:

> a lot of people keep asking . . . "How are you?" . . . The first thing the conversation drifts to is, "Do you still get bothered?" And then pretty well anybody that knows about it go out of their way to make things easier for me. They even go as far as helping you with your coat because you are the next thing to a cripple--because you had a heart attack. . . . To me it is almost an offense to have somebody even think that I am worse than anybody else.

He does not wish to be singled out for "special treatment," "I would make a crack and say, 'For Christ's sake, I am not dead,' or something like that. 'I could do it myself.' Very seldom people let you forget, and my wife, NEVER." Admittedly she reminds him in a more indirect way:

> She is more inclined to be sticky where exercise, food and general care is concerned. She is always saying, "I am going to put you on a stricter diet. You got to exercise more, get out of that chair, get away from the T.V.". . . . I know I am overweight, have been all my life, so I don't worry about

> that. . . . I haven't gained or lost in the last thirty to forty years, so why worry about it? . . . But she does have a tendency to react about it all the time. . . . At times it gets a little annoying.

MARK SHAW

Mark Shaw was six weeks old when his father was killed in World War I. His mother remarried. His step-father, who had one child, died of a heart attack when Shaw was eighteen years old. Then Shaw became the sole breadwinner: he supported his mother and step-sister. His mother lived to be eighty-six years old.

When Shaw had his heart attack, he was away from home on a business trip with a colleague. It was about eleven o'clock at night, and they were watching television when Shaw became aware that something was wrong.

> Something was pressing on my chest, or pushing on my chest, very hard. I knew that something was wrong, but I didn't know exactly what. It was very scary . . . I knew that something was really wrong.

He knew that something was wrong with him, and he was frightened. It happened so quickly; one minute he was engaged in watching a television show, oblivious to his bodily sensations, and the next minute he became acutely aware of his physical being. How could he ignore that tremendous force that was pushing on his chest? While he did not think he had suffered a heart attack, his colleague did, so he went to the hospital where he was admitted to the CCU.

On the one hand, Shaw's response to his heart attack appears to have been fatalistic. "If it happens, it happens." It is inevitable;

it is determined by fate. On the other hand, his brush with death left his will to live intact. As he put it, "I feel I was very fortunate, I have had a couple of knocks and I am still around, that you don't get ridiculous in the way you live." He seems to be saying, "I can take control and I shall; I can change my lifestyle and reduce my risks." There is a common lay belief that a third infarction is fatal (Monteiro, 1979). Shaw had "two knocks." Could he survive a third? He seemed less willing to tempt fate after his second "knock"; he was ready to abandon a lifestyle which his doctor accurately described in a conversation after his first "knock":

> He came in and said, "Let me see if I can identify your lifestyle." He continued, "You are the first guy down at the office in the morning." That's true. "And you are probably the last guy out," and that was true too. "And you have a couple of drinks when you go home after work." That was generally true. "Frequently," he said, "when you travel you go at night, so you can work all day, and you catch the night plane home." I had just finished doing this. And he said, "You smoke a box of cigars a day or a couple of packets of cigarettes."

Shaw responded, "Well, I smoke cigars."

The "couple of knocks" were to be heeded. They may even have saved his life as they heightened his awareness of his hazardous lifestyle. They put him on another path, a less hazardous one:

> I suppose I would have just kept plowing away doing all those things, and it would have created problems for myself . . . smoking particularly. I became much more aware.

Shaw is not a deeply religious man, but he has attended his church on a regular basis, and at one time was very involved in parish activities. His belief in God seems to be a source of solace for him. "If you don't believe in God, it must be awful tough on you to have no

religious connections." Does belief in a power beyond one's earthly station allow the individual to transcend the immediate and temper the fear of the unknown which a heart attack may engender?

Shaw spent two weeks in the hospital, and then he went home for a month. This was followed by a month's vacation in Maui. Following his discharge from the hospital, Shaw felt tired for some time--"I was pretty tired for a long time"--but after a month in Maui he felt "a lot better." This trip to Maui was planned for him by his eldest son:

> My eldest son made all the arrangements, everything was done. I was pretty 'pooped'. . . .He got me a first classticket. That is a great extravagance. I never travel first class, but it was very nice. Everything was well organized.

Shaw was able to accept help when he needed it. He was appreciative of what his son did for him. He knew his limitations, and instead of insisting that he take control of his situation, he allowed his son to plan the vacation which allowed him to "get away from it all." Did this period away help in the transition from a hectic pace to a less hectic lifestyle?

Shaw, who owns his business, returned to work instead of returning to a ~~retirement village~~ or a senior citizen's community. Returning to work indicated that in spite of his illness he could still pursue the goals that mattered to him. His field of endeavour is very stressful and fiercely competitive; only the most astute survive. He has survived and has been very successful. He knew his limitations, however, and did not altogether return to his old routine. He is perhaps more cautious now. His son, who works with him, assumed more responsibility for the day-to-day activities. Since Shaw was in a position to be selective about what he would do, the tenor of these changes was in the

direction of limiting his activities and responsibilities. What was it like to take a less active role in a business the individual started and which flourished under his leadership? Could he slacken his hold on the reigns of power?

> Well, if you are philosophical about it, you know if you hadn't made it , somebody would be doing it anyway. So you might as well make up your mind that other people know how to do things and can be responsible for things. So you gradually let go.

Is it easier when one gets older to "let go," to hand over to the younger generation? Admittedly, for the older person it is only a matter of time before the individual may be forced to reduce his input, and it is possible that a heart attack may only accelerate the inevitable. Shaw was sixty-four years old when he had his heart attack. A heart attack may also bring into sharper focus that time is running out. It forces the individual to modify or to change his goals if he wishes to survive. But for Shaw, survival did not mean existing for the sake of existing; it meant being able to enjoy life and his family.

Returning to work in a different capacity is not without its difficulties. Shaw had to work at being less involved, but this was not always effective. It was easier for him when they maintained the status quo. Deviations, or what he considered to be risk-taking activities, were difficult to tolerate and were not tolerated:

> And when I saw them going off in a different direction, I would get firm. But I tried not to get upset about everything.

Shaw's counsel, however, is heeded by his son. So instead of feeling useless, he feels wanted: "There are certain areas where I can still be advantageous to our firm." He remains part of a vital business ven-

ture. He was and still is an expert in his field; as an expert he expects others to comply with his advice.

In spite of the fact that Shaw did modify his work load, over time he began to take on more and more responsibilities, and two years later he may have had another heart attack:

> I suppose it was a heart attack. . . . I was going to Toronto, and I had a lot of things I was trying to do. . . . I went to exercise before I was to catch the plane in the afternoon [Shaw had been attending a cardiac rehabilitation exercise programme on a regular basis]. I had been up late the night before. I remember I had been working pretty hard in planning the trip [a business trip to Toronto]. . . . I went through the exercises. . . . I was alone in the changing room, and I just didn't feel well. I felt awful all of a sudden. And I thought, if I fall no one will know I am here, so I went to one of the nurses and I said, "I don't feel very good." She just looked at me and backed me onto a stretcher. An ambulance was called and I don't remember anything after that. . . . The next thing I remember was opening my eyes and a bunch of guys standing over me and my chest was just about caved in and a guy said, "I guess you will make it now." . . . I felt as though I had been kicked by a mule for about two days. And so that scared me.

This incident motivated Shaw to "release more and more" of his responsibilities. He felt the second incident happened because he "started doing the same thing all over again." "Now," Shaw says, "I take holidays, I play golf often." This does not mean, however, that Shaw has retired from leading an active life. Before his heart attack, Shaw attended "all kinds of functions and sat on numerous boards"; immediately after his heart attack he resigned "from virtually everything." Gradually he accepted invitations to sit on a number of boards, but he "does not do a great deal of work."

There was one exception, however. Shaw assumed responsibility for organizing a major international event. This time he was able to

accept his limitations and he "listened" to his body. Whenever he began to feel tired, he would "quit" and go home where he would engage in a different kind of activity. He also credits the success of this major undertaking to a very efficient staff. Shaw was able to recognize his staff's talents and to delegate tasks. Shaw had learned from his second experience to take life at a slower pace, and although the pace was slower, he was still able to soar to great heights. This particular undertaking was a colossal one. It will probably be the major undertaking of his life, since it would be difficult to surpass. He was able to accomplish it to his satisfaction. This was indeed a success story.

As far as his work is concerned, Shaw says:

> I still go down, but I do not concern myself with who we hire and how much we pay. I don't concern myself with the leases . . . and the details of procedures that are going on. . . I look after certain selective clients, and let other people do the details.

His attitude has also changed. Once, losing a contract would have been a major disaster. Now he says, "If you lose something, you lose it. I don't get myself all in a panic about it." Shaw has suffered a loss--loss of health. This loss is more important to him than losing a contract. His priorities have changed. Once he took good health for granted--not so anymore. Now he has learned to pace himself. What happens when Shaw pushes his limits? "I get pains through here [he slides his hand across his chest]. I can feel it. I just know that it is time that I stopped." Pain, while it is to be feared, is also to be heeded. It has become an important warning signal. What would happen if this warning system failed to function?

Since his heart attack, Shaw exercises regularly, he "works out" three times each week with other post-MI patients and he "feels much better." He also credits his regular exercise with his ability to maintain his ideal weight. Being in the exercise programme, from Shaw's perspective, ensures compliance with the medical regimen since the individual is under constant surveillance, not only by the health care professionals but by his peers:

> I know a couple of guys who went there for awhile [to the exercise programme]. . . . They feel good now, but they do not come any longer. I notice that one of them has started smoking again. . . . You know, one day we were talking, and some guy came in there and he said he couldn't wait to get away because he wanted a cigarette. All the guys said, "What kind of a darn fool are you?" . . . He wasn't convinced. Like a kid he was going to beat the teacher. But all the guys said how stupid can you be . . . nobody smokes.

The group demands adherence to certain standards, and those who do not abide by the rules become outcasts: they do not fit.

At the time of our conversation (December, 1984), it was five years since Shaw had had his heart attack. He continues to have a check-up every six months. Having a check-up is as routine as exercising three times a week and equally non-threatening. A check-up is a part of the course, not something to be feared. Shaw takes it in his stride. He says:

> in an exercise programme such as ours, when you are followed all the time, it is not as difficult for people. I have talked to other people and they don't have that kind of follow-up. They have a check-up once a year and that is always a concern to them, how they are.

Being in the exercise programme, he <u>knows</u> how he is. If he misses a week or so, he does not "feel the same"; when he exercises regularly, he "feels good." So he knows how he is doing.

It is not only the exercise programme which helps Shaw to take his check-ups in his stride, but it is also the support that he gets from the exercise group, people who have had a similar experience, and seeing how they are progressing. A mysterious bond connects them:

> Well, I think one of the great advantages of that programme is that you are with the same guys who are all carved up [some have had open-heart surgery]. We all have problems and we shower together after the class; people talk quite freely about what their problems are and everybody understands it. Someone would say,"I am having a stress test tomorrow". . . but it doesn't seem to be a big deal. . . . That it is something that is really going to kill them because everybody has been around someone who is stretched from here to here [refers to the incision on the thigh where the vein was removed for the by-pass]. . . . I think that is a very valuable thing for anybody who has had a heart problem to be associated with.

In the group, the individual may discover others who are worse off than he is, and they survived; that sustains him. He can survive too. The others are living proof that certain treatment modalities (e.g. surgery) work, and if his situation deteriorates there are always some other possibilities.

The group sometimes gets together for social events. When I spoke with Shaw, they had just had their Christmas party, at which the master of ceremonies, according to Shaw, said, "I have never seen a happier looking or healthier group of people, ever." Shaw continued, "And every blessed guy and some of the women were all heart patients, but they were dancing. . . . They were all happy people." Being with the group re-affirms the individual as a whole human being. This is a group of people who are doing what others do when they get together. They dance and enjoy themselves; they can put the cardiac event behind them and get on with living.

Knowing exactly what happened to him is very important to Shaw. It negates the need to phantasize. He knows--the doctor showed him the angiogram:

> He [the doctor] sits down and he says, "Here's the picture." It is this one [a coronary artery] and here is that one [another] and this is the one that is seventy percent blocked. . . . It gets so that it is not such a horrifying thing. . . . If you don't know what is happening to you that can be very terrifying. I want to know.

Shaw has nine children, and seventeen grandchildren, and a very supportive wife who apparently monitors his activities quite closely. Indeed, he takes more vacations, but he still continues to go into the office early and leave late:

> My wife bawls me out for that. I go down, I enjoy life, I don't want to stop and not do things.
>
> She says take your medicine, don't do this, behave yourself, it's no fun for me if you disappear [he laughed]. . . . She is a pretty good gal. She is not one of those people that is all "weepy" and "waily" and so on. She is a very practical gal. You have to take care of yourself.

Does having a wife who, from the individual's perspective, is interested in his welfare make it easier for him to take care of himself? Others may label her admonitions as being overprotective, "fussing," a hindrance to the post-MI patient's recovery.

Sometimes when Shaw returns home from work, he is tired:

> Some days--well, like last night--I was tired. I came home and I got sitting in the big chair reading this paper. . . . I knew I was tired and I was looking forward to getting home. Not that I don't want to go home. Mary was preparing supper. I fell asleep, and she let me sleep. So we didn't eat until 7:30 p.m.

Having a caring wife and a peaceful home environment make life easier for Shaw. At home he can recuperate after a busy day at the office. His wife is able to create a peaceful environment; home is a safe

refuge. There he can escape the hustle and bustle of the everyday world. While Shaw is able to meet his need for rest and relaxation at home, they still maintain an active social life. They entertain, and this is not stressful for Shaw because he sees his wife as a capable hostess:

> She is very easygoing in that regard. She entertains well, she does it, and knows how to do it. It's not a big deal for her. Some gals get into a great flap when they have a party. She doesn't.

Shaw believes that you can do anything if you want to. "You can stop eating meat if your want to, stop drinking if you want to, you can do anything you want to--if you have some reason to do it." The reason is the motivator. Shaw's desire to live, not as an invalid but as a productive person, has given him the incentive to instigate life- style changes. Immediately after his heart attack, Shaw made a number of dietary changes; but as time passed, he lifted some of the restrictions, although he continues to consume "a lot more fish and vegetables" now than before his heart attack. One of his major dietary changes related to the consumption of eggs:

> I used to have two eggs and bacon every morning. That was my big meal. I always worked on the principle that if you ate a great big breakfast and didn't eat for the rest of the day, it didn't matter.

Shaw continued:

> I used to enjoy drinking. I still do. It was nice to come home and have a nice drink, but I don't do it anymore. I have a cup of tea or a glass of juice.

At first the post-MI patient may be overwhelmed by the "don'ts." He may be forced to give up a life that he enjoyed. Admittedly, there are substitutions; however, they are usually not the type that the

individual would freely choose. At first there seem to be so many things that the individual should not do:

> then you find out there are things that you can do. I started playing golf, I still ski--I don't ski as fast as I used to [Shaw is now five years older. Is this slowing down to be expected with age?]. I don't hit the ball as far as I used to, I don't walk the golf course as conveniently as I used to. I use a cart now where there are hills, and that kind of thing. But life is not bad. It can be quite good.

Some time ago, Shaw and several of his friends went to California to golf for ten days. Having the financial resources makes more options available to him; it gives him flexibility. He continues to work because he wants to, and he enjoys what he is doing. He can take a vacation whenever he wishes to do so, because he has confidence in his son's ability to carry on the business in his absence. His stepfather's situation was in stark contrast to his own:

> It was during the Depression, during cold weather, he would have to stop [due to chest pain] three to four times before he could make it home at night from the street car [the "stop" was half a mile away from their home]. The economic situation was desperate. He went to work whether he could put one foot before the other or not.... Probably that is what killed him in that he <u>had to</u>. And not a particularly attractive job . . . maybe not satisfying. . . . I am lucky. . . . I like what I am doing, I like my job, I enjoy my life. I enjoy going out and seeing some of my old clients.

We take living for granted, but a heart attack brings this into question. It calls for reflection upon one's way of living, more specifically, one's lifestyle. Reflection may reveal deleterious behaviours such as smoking which are, nevertheless, enjoyable. Hence reflection may create more problems than solutions; moreover, the intended solutions, that is the lifestyle changes, may become problems. Should the post-MI patient comply with the medical regimen, no matter

what? Shaw counsels:

> Follow the professional advice that you receive. . . . It is silly to get professional advice and ignore it. . . . Make the necessary changes. Do it.

The individual, however, may wish to continue to live as he did before his belief that he was indestructable was shattered. He cannot choose not to have an MI, but he can choose how he will live after the event, and this may mean noncompliance or only partial compliance with the medical regimen.

BRENT HAMILTON

> I never did finish school. . . . When I was fifteen years old I began driving a truck. . . I always figured someday I am going to be the boss and own all the equipment, and I did. . . . I wanted to get ahead, I wanted a nice home for my wife, I wanted all the good things.

"Get ahead" he did. By his fortieth birthday, Brent Hamilton had realized his dream. Admittedly, his company was experiencing financial problems, but the situation was not desperate. He had survived other crises and he was confident that he would overcome this one too. Then, in September, 1968, he had a heart attack. At first it seemed as though his heart attack would destroy what he had worked so diligently to attain. "I thought I was going to lose everything because I didn't think I could work anymore." But Hamilton recovered, and redoubled his efforts. Today his financial assets exceed by far what they were in 1968.

> I have a nice home, nice cars, a big yard, over one hundred pieces of equipment, an oil plant, trucks. . . . So we are doing pretty well.

Hamilton's heart attack occurred on a Sunday:

> I had pains in my arms and my chest. I had arthritis . . . so I took some aspirins and I laid down. . . . We were going to visit my in-laws. . . . I laid down for awhile. It didn't seem to help much, so I thought I would go anyway. We drove out as far as Wetaskiwin. They lived in Camrose. . . . I said to my wife, "I don't feel very well. Maybe I should go to the doctor because it isn't getting any better." . . . We went to the Duggan Hospital.

Hamilton was admitted to the hospital. He was given oxygen and then he felt "fine"; in fact, he thought he would be able to go home. "I didn't realize what really happened." It was from the resident that Hamilton learned that he had suffered a heart attack.

> It was sort of a surprise. Yet I thought there was something wrong as I was coming into town. Close to the hospital my fingers started tingling--a numbness. . . . It was a surprise . . . I didn't think I had a heart attack. . . . It was quite a sharp pain in my chest, then the pain sort of went out in my arms, then there was this numbness, and I was a little short of breath, too. . . . You sort of feel you have to breathe and you can't breathe. . . . You can't get no air.

This made him "panic." Hamilton's pain was relieved by the administration of oxygen; but when the oxygen was discontinued, the pain returned, and this disturbed him. "I thought I was going to have another heart attack, that something was going to happen to me."

With the realization that he had had a heart attack, Hamilton asked the inevitable question, "Why me?" Although he knew of others who had suffered an MI, he had never thought that it could happen to him. Illness was not a part of his life. It was something that happened to the other person:

> I did ask, "Why did it have to happen to me?" A lot of the time you hear a friend or someone that you know who has been in the hospital with a heart attack; you don't think it could happen to you. You always think of someone else.

In the CCU, Hamilton experienced chest pain from time to time. The pain constituted a death threat. He thought he could die at any moment:

> It is a scary feeling because you think you are young, you have a young family, and something is going to happen to you--you will be gone.

Death would not only rob him of his most precious possession, life, but it would also rob his children of their father at a time when he was needed most. Death not only destroys one life but it changes the lives of significant others in unpredictable ways.

This was the first time that Hamilton had been an in-patient in a hospital. His first three days were spent in the CCU:

> Being in the CCU where everything sort of looked dark,.. it is not bright in there, they haven't got too many lights on, and there were a lot of sick people, sicker than I was. . . . It was scary. I was scared.

On the one hand, seeing others who are "sicker" may be comforting; on the other hand, what does being placed in such an environment mean? Hamilton was not oblivious to his surroundings. He remembered one patient in particular:

> I guess he was older than I was, but he had a problem one night. They called the doctor. I guess he had a blockage in his legs, and I guess they rushed him in. They saved him all right.... He had really terrible pains in his legs. I remember he complained about his legs a lot. Then there were some other fellows who were not quite as bad. There were some like I was. But there were a few bad ones.

Hamilton, like the other patients in the CCU, was "hooked-up" to a monitor and he had an intravenous line. At present (February, 1985), Hamilton is a tall, slender man; but at the time of his heart attack, he was overweight, and his doctor was very candid when he saw him for

the first time:

> Dr. James came in. He remarked, "You are forty years old. What are you doing here? Look at that belly on you." I had quite a bit of weight on--I was a lot heavier than I am today. I weighed 180-186 pounds. Today I weigh about 170. He checked me out and said, "There isn't much wrong with you." He pulled the IV out right there. . . . They put me in another room just off the CCU. I was there for maybe one night, and then I was transferred to the ward.
>
> I thought what kind of a guy is this? I couldn't believe it. Of course, I didn't feel good. He made some other comments and then he came around again, then I got to know him a bit more. The first time I thought, "What a doctor!"

The doctor's "inappropriate behaviour" may, on the one hand, be reassuring--would he berate Hamilton if his condition were serious? On the other hand, it may make the patient feel helpless; he was now at the mercy of someone who ridiculed his misfortune. How could he share his feelings and concerns with this doctor? What would trigger the next tirade?

In the ward:

> I guess I started feeling sort of sorry for myself. . . . There was also another fellow alongside me. . . . He must have been about fifty-two years old. I got to know him. . . . He was a sort of friend of mine. . . . One afternoon I was lying in bed and my brother came to visit, so this fellow who was talking to me said, "I will lay down for awhile, while you visit with your brother." . . . He made a funny sound so I looked over and I said, "I think you had better call the nurse," and he did. . . . They worked on him for a good half hour [this man apparently had had a cardiac arrest]. My brother and I left the room. They [the medical team] brought him back [that is, they resuscitated him, but he died a few days later]. It was quite an experience. It really upset me, but I got over it after. I think they gave me some Valium.

Valium was the antidote for his fear and anxiety. Viewing the arrest was a source of great distress. What did Hamilton find upsetting about the experience? He said, "When somebody dies you think you are in the

same position, and I don't know, all I know is that it got me upset. . . . I guess I thought I was going to be next." He identified with the victim, he saw in his roommate's arrest and subsequent death a symbol of his own mortality. Death brought him face to face with the inevitability of his own eventual demise.

When he is busy, the hours and minutes seem to fly by, but those same hours and minutes seem like an eternity when he is incapacitated. Normally, Hamilton was involved in an incessant struggle to achieve more and more in less and less time. Now he had the time, but he was in the wrong place. Time and place have to come together. The period of enforced physical inactivity was not a respite from the hustle and bustle of his everyday lifeworld. He had to have "a lot of excitement." Now he must endure waiting. This waiting was due to the conflict between two different time systems--biological clock time and the time of the clock on the wall (Hall, 1984). He was bored. Time drags when the body clock and the clock on the wall are out of sync (Hall, 1984).

Hamilton was in the CCU for three days, which he found to be "a very long time." On the ward it was even worse. "That was long. I couldn't wait to get out. . . . It was long days and long nights." Waiting was boring, "an inefficient use of time, empty and unproductive time" (Fujita, 1985, p. 107). Furthermore, this time was wasted. It could never be reclaimed or recovered. Hamilton was used to being busy, and when he was busy he experienced time in a different way than what it was in the hospital--"the hours, the minutes go so slowly." On the contrary, when he was busy, "they go so quickly. . . . When you are sitting around everything goes slowly. So that is why I felt it took

so long." Now the hours seemed longer and emptier. Moreover, being in the hospital is like serving time. The doctor is like the judge in the penal system: he decides the length of your stay. "I had to wait my time, till the doctor told me I could go."

On the ward, the visiting hours were very flexible and Hamilton had many visitors. This helped him to pass the time. But he was not used to just passing time--his hours and minutes were filled with meaningful activities. Hamilton, subsequently, suffered a second heart attack. This time he "brought some work in . . . just something to do." It helped him to pass the time in a productive way. Hamilton thrives on a rapid pace and he still finds it difficult to live life at a slower pace:

> I tried to slow down and my wife tells me I am supposed to slow down. . . . If it is a quiet day I have to have something else going on. There is always something happening.

Hamilton returned home to convalesce following his discharge from the hospital. Usually, he rarely stayed at home. "I always had to be up. . . . When a person feels that way [meaning ill], I guess you have to stay home." He passed the time by watching television, reading, sleeping, going for walks twice a day, and accompanying his wife on her daily errands outside the home. His wife took time off from their business to be with him while he was at home. He recalled that she observed him quite closely. "Don't do this, don't do that . . . as far as eating too, watch what you eat." How did he react to this? He was accustomed to doing what he wanted to do, yet he said he accepted it. What does "accepting it" mean? Did he change from being an active to a passive person? Does the individual's hospital experience prepare him

for this less active role, or is it how he feels, that is, the fatigue, that forces him to accept a less active role? Or is it a combination of both--that is, his hospital experience and the fatigue? Or is he motivated to comply by fear of a re-infarction? How does it affect his way of being and his interaction with others?

Hamilton's stay at home was of short duration. At first he returned to work part-time. He could be selective about when and for how long he worked because he was self-employed. He found that he could tolerate working in the mornings but that he was too tired to work all day. He would rest in the afternoons. His body dictated how much he could do. It placed constraints on him. Yet he quickly recovered, and in about three weeks he was working full-time once again. Sometimes Hamilton still feels tired; he now has a chesterfield in his office which he uses occasionally when he is too tired to carry on. Although ever since he has been exercising regularly, he is less tired than he used to be.

For some time after his heart attack, whenever Hamilton experienced "any little pain," he would go to the hospital emergency or to his doctor's office. He feared a recurrence. Each time he thought "that's it." But when his doctor explained to him what had happened, he knew "what the different pains were":

> It is when you do not know you think of all kinds of things, and it doesn't relate to it at all sometimes. . . . Just after my first heart attack, I had a pain and I thought, "Something is happening," and it wasn't really; it could be an upset stomach or something else.

Furthermore, when he enrolled in an exercise programme for cardiac patients, he "felt better" and his self-confidence increased. Conse-

quently he no longer frequented the emergency department or his doctor's office.

His confidence got a boost when he had coronary arteriography in the late 1970s and he learned of the extent of the damage to his heart:

> We didn't know; the doctor really didn't know for sure what had happened. He didn't think I had a very bad or serious heart attack.... And so finally one day he made the decision. He said, "Let's get this done so we can really know where we are at"; and I really wanted to get it done. . . Since the angio I really changed when he explained that I had very little damage. He told me all that I could do and I felt a lot better.... Now I feel just like new.

Until the late 1970s, Hamilton had been living in the dark. With the advances in technology, however, the doctors were able to ascertain the exact extent of the damage done by the infarction. It reduced the uncertainty. Hamilton was reassured by the results of the coronary arteriography. The damage was minimal.

In 1972, Hamilton appears to have had a second heart attack. This time the pain was less severe than for his first heart attack:

> I had a little pain, and my hands got numb too. But it wasn't near the pain that I had with the first one. I just felt rough, just terrible.

The diagnosis was not a surprise:

> Well, of course I was thinking about the first, that is all I thought. Every time I had a pain that is all I thought of . . . a heart attack.

He was hospitalized for two weeks.

Following his second heart attack, Hamilton was motivated to modify his lifestyle. These changes were made gradually. One of the major changes related to altering his eating habits so as to maintain his ideal weight:

> I didn't want to walk around with a big pot, and I didn't want to be sick.... I decided. I know it is real hard, especially when all your friends around you are eating and drinking and you are just sitting there, but it's okay.

Food is very central to our lives, not only for survival but as an integral part of our social relationships. With certain people we have certain types of food. With others the fare changes; hence, making changes in what we eat may alter our social relationships. It may even mean avoiding certain individuals.

Hamilton enjoyed "snacking" between meals; he indulged in milk shakes, hot dogs, and "greasy" foods. How difficult was it for Hamilton to change?

> It was a little hard. For years you have been doing it. Then all of a sudden you can't eat that; you have to watch what you eat. It was hard to start with. . . . After a few years have gone by, you get used to it. Sometimes you get a craving for some of the old things. You maybe have a little sip.

For Hamilton, food and work were inextricably linked, at least so it seemed to him. He felt obligated to entertain his customers; this meant business lunches. Fortunately this has changed in part due to changes in the business world:

> Things have changed too in the business world. One time the business people--your customers--expected big lunches, and they all wanted drinks, and that kind of thing . . . I don't mind taking a customer out to lunch, but I don't want to sit for half the night in a bar. That's what a lot of these guys do. It's a kind of bribing, you might say. . . . I don't operate that way. If I can't get my work with service and my word, tough.

Altering eating habits may be extremely frustrating and unpalatable. For some it may be a choice between living, admittedly, a different way of life, or being incapacitated over the long term.

Hamilton chose the former. In order to cut down on calories, cholesterol and saturated fats, he made drastic cuts in business lunches. For the obligatory ones, he limits his intake to a bowl of soup and a salad. Thus by maintaining control of the environment, he eliminated a deleterious effect on his health.

Another major lifestyle change occurred when Hamilton began to exercise on a "somewhat irregular basis." After his first heart attack he invested in an exercise bike. At first he was diligent about exercising, but over the long run he found excuses for missing:

> I tried faithfully, and then something would come up that night. Then I would put it off for tomorrow. And sure enough the next night there is something else.
>
> I found it boring sitting on that bike for twenty to thirty minutes with no one around. That's why I like going to the programme.

For the last three years, Hamilton has been participating regularly in the cardiac exercise rehabilitation programme. He attends twice a week, although he believes that three times would be ideal. However, he cannot find the time to fit in a third session. He is at the gym at 6:30 a.m. He jogs for half an hour, then exercises with the group. This is followed by a game such as floor hockey. He is in his office by 8:30 a.m. The exercise programme fits into his schedule. He is an early riser, so being there for 6:30 a.m. is not an inconvenience. In addition to the exercise programme, Hamilton capitalizes on other opportunities to maintain his physical well-being--he seldom takes an elevator. He climbs several flights of stairs daily.

Hamilton's work world is very stressful and demanding. To combat this pressure, he feels that time away from it is mandatory for surviv-

al--ideally a week or two away three to four times each year. He has, however, been unable to put into practice what he believes, although it is within his power to do so. "I still feel I can't leave because there are too many things I have to look after." Since his heart attack, however, he takes a winter holiday. He also started curling which meant he had to curl twice a week. He found that this was too much. They started at 9 p.m. and he did not arrive home before midnight. Now he only curls in the bonspiels.

As far as physical activities are concerned, Hamilton feels that he can do "anything that anybody else can do," although he admits that if he is lifting a heavy object for the first time he "watches" what he can do. "Sometimes I think that maybe I am doing the wrong thing. Sometimes a person does not think." If he stops "to think," he may have second thoughts about what he can and should do. Being mindless about the activity is being careless about one's capabilities, and it could be detrimental to one's well-being.

Owning his company means that Hamilton can modify his work load and have more "free time." But letting go has been a gradual process. This has been facilitated by his son's involvement in the company, which began six years ago:

> At work I am protected. You see, my son has taken over and then I have an operations' manager. . . . It is not nearly as hectic as it was a few years ago. . . . The people that I have hired take a lot of the work load so I have a little more free time. . . . I am not pressed that much, except I do the major things like lawyers and accounts work, all that stuff. . . . Then with going to the exercise programme it is not as stressful as it was.

While Hamilton has made changes in his work situation, it is hard

to change old habits and he feels that at times he is "pushing" himself when he does not have to:

> At one time I was in a position where I had to, but now I am in a position where I do not have to. . . . I feel if I am not in the office between 7:30 and 8:00 a.m. nothing will happen. . . . But there are capable people there . . . still I feel if I am not there everything will go to pot. I have got to be there in the morning. I have to open up, I have got to be the one that unlocks it, turns the key. . . . I was thinking of making changes. Instead of going in early, why not sleep in one morning till eight o'clock at least.

Hamilton is at home by six o'clock. He then prepares supper, so when his wife returns home supper is ready. (She works from noon, in his office, and is usually home between 6:30 and 7:00 p.m.) Preparing supper is not an inconvenience; he has always liked cooking. During his convalescence at home, following his heart attack, he began this practice. "It was one way of passing the time. I like something to do always. So that is when I got started. It was something for me to do."

Hamilton's wife was very supportive during his illness and a new relationship developed toward greater marital cohesion after the event. Furthermore, he attributes his will to live and to overcome the event to his wife and children. At the time of his heart attack, his three children were living at home. Now they have all left home; two of them are married.

Before his heart attack, Hamilton was very involved with his work situation, he had achieved his lifelong goal of being his own boss and being a successful businessman through hard work and long working days. There were conflicts between the demands of his work situation and his family, with the former taking priority. His family "came second."

Nevertheless, he did "look after them," meaning that he provided for their material needs. After his heart attack his priorities changed:

> You look at things differently. You think maybe your family should come first, before work. . . . I think that is the way I went. . . . But I still . . . work, I could do it. Before, I was spending a lot of time with customers when I didn't have to spend it. And if you really sit down and work it out, you could spend a lot more time with your family and still achieve more work.

Before his heart attack, Hamilton was not a regular church-goer. "Maybe about once a month" he would accompany his wife to church on Sundays. Since his heart attack he attends church regularly. He "enjoys" going to church and feels that his experience with illness (the M.I.) has made him more religious.

Sundays are restful days for the Hamiltons: sometimes their children visit, at other times they go visiting, or he may just "putter" around the house. It is the only day that he does not go to his office.

There is one aspect of his lifestyle that Hamilton has not been able to modify or to change and that is his time consciousness:

> I guess I am a very aggressive person. Time means a lot to me, I can't be late. If I tell someone to be there and he is five minutes late I have no patience with him. . . . My wife, she is the opposite--she can't seem to get going.

In his work situation he is frustrated by people who are late. Fortunately for him, his son and operations' manager have more contact with customers, so he is spared this aggravation.

Hamilton's very busy schedule makes it difficult for him to be less time conscious. Time determines schedules:

> You are meeting deadlines all the time. My problem is that I take too many things on in one day. I might have an appoint-

> ment downtown. I go to the exercise programme at 6:30 a.m.; meet with my lawyers at 8:30 a.m. Then see somebody else. Then I have to meet somebody else at noon. That type of thing. I have too many things going on in one day. I always feel, "what I can do today, why wait for tomorrow?" Because tomorrow might have something else going. . . . At night when I go to bed I plan what I will do the next day. . . . I even know what I shall wear in the morning. . . . I have it all figured out.

Every minute seems to count for Hamilton, and this could be a source of frustration for others who must interact with him and who do not share his obsession with time. Time is to be used for productive endeavours not wasted.

Hamilton's obsession with time is not shared by his wife:

> That's the only problem I can't cope with. I like to be there on time, and she is of a slower pace. We never get going on time.

He admits he cannot change her, and she cannot change him.

Once a year Hamilton has a check-up. It is easier now than it used to be because he is physically fit. At first, the treadmill test "was pretty tough. You were really puffing. You were just about worn right out by the time they shut you down." In other words, the fitter the individual is, the better able he is to "survive" the testing ordeal.

Sixteen years ago Hamilton had his first heart attack, and it is twelve years since his second. Does he ever forget that he has had a heart attack?

> No, I think it is still in the back of your mind that you have had one. And I think you respect a lot of these things that you should be doing.

If even it were possible for the individual to forget there always seems to be someone there to remind him, such as his spouse:

> She [his wife] says, "Why are you doing this? You shouldn't be doing this...." She reminds me ever so often. When I go out shovelling [snow] she says, "You shouldn't do that. Why are you doing that? Why don't you let someone else do it?"

The exercise programme is also a reminder and it provides opportunities for sharing the experience with others:

> Everyone I run into at the gym or the clinic seem to talk about what had happened to them.... Every time I meet a different guy, we get talking just while we are dressing, he tells me how his happened. Maybe I tell how mine happened. ... You learn a little... you learn how things happen, how it could happen.

Thus interacting with others broadens one's horizon and provides an opportunity to compare notes. He "feels fine," however, and engages in all of his pre-infarction activities. As far as he is concerned his heart problem is over, although forgetting is never fully realized.

KENNETH MARTIN

Kenneth Martin began his personal account by recounting the events that preceded his admission to the CCU. His heart attack was a "complete surprise" for two reasons. First, he was twenty-eight years old. Second, it came "so totally out of the blue." He had always thought of himself as a "reasonably fit person." Indeed over a period of months he had been doing "quite strenuous exercises." He did not fit his stereotype of the typical heart attack victim; he was in good physical condition with demonstrated feats of physical stamina.

Martin had his heart attack before he immigrated to Canada. It occurred in the land of his birth, a progressive Commonwealth country.

In the time period prior to his heart attack, Martin had driven about one hundred miles from the city where he practiced law to see a client. He returned home between ten and eleven o'clock at night:

> I hadn't felt that well during the day. I had a cold at the time, quite a heavy cold. . . . Around 3 to 4 a.m., I woke up and it felt rather as if I had a hot poker up the middle of my chest, my sternum. And my left arm and side had gone quite numb. . . . I can remember thinking quite clearly that I must have a bad case of indigestion.
>
> For a time I lay in bed alongside my wife. I didn't wake her up. . . . I thought it would pass. . . . I suppose a half to three-quarters of an hour had gone by when I realized that this thing was not going to go away. I really felt quite dead down my left side and the pain was not abating at all.
>
> I woke my wife up and told her that I thought I had a bad case of indigestion. . . . I think I was on the verge of losing consciousness.

Now it was time to act. His wife telephoned their general practitioner, who was also a friend and lived within the vicinity. The doctor was there in three minutes:

> He [the doctor] took one look at the situation and sent me off to the cardiac ward by ambulance. I was then hospitalized within a matter of twenty to twenty-five minutes after arrival.
>
> He said something like, "This would be quite extraordinary in your case, but nevertheless, I think you have had a heart attack and I am shipping you straight to the Cardiac Emergency Unit."

Martin is not sure that he believed him; nevertheless, his freedom to act was severely compromised, so something was amiss. The increasing pain was proof of this. Within a matter of minutes he plummeted from a "fit," independent individual to an incapacitated, dependent being. He had come face to face with what could be the end.

On arrival at the hospital, Martin was "struck" by the delay in

getting from the first floor to the sixth floor where the CCU was located. It appears that the ambulance attendant did not know where the elevator was located, and it took him some ten to fifteen minutes to arrive at the CCU. The inefficiency of the ambulance attendant was in direct contrast to what happened when the elevator reached the sixth floor:

> The team, doctors and nurses, descended on me. It was rather strange, after being left out in the cold for a period of time, then it is treated as a cataclysmic emergency when you finally get through the door.

The therapeutic plan was instigated immediately:

> I was "hooked-up" to all the heart monitors and all the paraphernalia that attends these things. A young intern came in to see me.... I was still "woozy" because they had given me all that "junk," and he said to me, "We have just got the lab tests back and you definitely had a heart attack."

Even in that "twilight zone" of being there and not being there, in that dream-like drug-induced state, Martin heard what the intern said. The doctor's clinical impression had been confirmed by the diagnostic tests. He had had a heart attack. Martin was not prepared to accept the diagnosis; there was still some lingering doubt and he questioned the intern. Martin reacted "by shutting it out from the word go, right from the very instant it occurred." How could he "shut it out" when he was in the CCU, hooked-up to a monitor, and he knew that his blood enzymes were elevated? He was used to "shutting out" certain elements. In his professional practice he had learned to do this. He had to. It was the only way he could function: "You could only function when you have three or four hundred court files by a rigid system of compartments in your mind." So he now applied his accustomed way of coping to

his present situation. It had worked before, but did it really work in this situation?

Martin did not see his cardiologist "until quite late the following day." From the time of the event to the time he saw his cardiologist was "a bad period." "I got myself into a complete 'tizzy,' for somewhere in there the notion that I had a heart attack sunk in." The diagnosis sparked a number of concerns:

> A whole kaleidoscope of things went through my mind at that stage. "God forbid, here I am at twenty-eight, having a heart attack." . . . For someone like myself, leaving that kind of discussion for too long is not a good thing. Simply because even a period of twelve to eighteen hours is too much time to mull things over. . . . That clearly did trouble me and, subsequently, I had quite a few problems with the whole business.

While waiting to see his cardiologist, he wondered and worried about how it would affect his family and his professional life, and what adjustments he would have to make. His head was filled with questions but he had no answers:

> I was already thinking about these things, yet I hadn't had any advice other than this particular __ __ __ had occurred.

Within a couple of days, Martin's concerns shifted from himself to his family. What would happen to them? He asked his wife to bring in his "deed box." He had not looked at his papers for a long time. He had his secretary come in and he dictated a more up-to-date will. Did he feel that he could die at any moment, hence the urgency to get everything done at once?

Martin had mixed feelings about leaving the CCU where he spent one week. On the one hand, "moving out of the CCU must be some kind of sign that one is getting better." On the other hand, he worried be-

cause he wondered if "they really knew what they were doing." Why this cause for concern? Martin saw himself as a special case, as some kind of anomaly. "I think what worried me deep down was they still had not been able to explain the situation." There was that lurking fear "that they are shoving me out of here before they really know what is wrong." The transfer out of the CCU seemed to raise more doubts and fears and contributed to an increased feeling of insecurity. Although he understood the situation "intellectually," his insecurity was rooted at the emotional level. He continued to mull over his situation but he was not incapacitated by it. He was a man of action.

Martin had always been a "fairly determined soul." He attributes this to "a strange phenomenon,"

> really close to an inferiority complex even though I never had any difficulty in sports or school or anything else. Being top of my class. . . gone to graduate school . . . indeed, I had got on fairly quickly at a fairly young age. But the reason for getting on was overcoming those other things as it were. So I think on that particular process one of the things I learned was to put one foot before the other and to keep going.

There is this linear progression to a clearly-identified goal, and obstacles which are encountered are seen as challenges to be overcome by using a problem-solving approach. Likewise, his heart attack was seen as something to be overcome, and this was to be done by "facing it head on." He was ready to do battle; he would have to marshal the life-giving forces within him. One avenue for doing this was by developing and implementing a cardiac rehabilitation programme, something that he would have to do almost single handedly, since there were no organized rehabilitation programmes (with an exercise orientation) in

his country in 1974. Exercise was to form the basis of his approach and was geared to improving his functional capacity. Hence, he was facing another challenge, and this became the focus of his attention within a day or two of the event.

Admittedly, he had been given literature on cardiac rehabilitation by the hospital staff, but he wanted more, so he enlisted his wife's assistance:

> I immediately said to my wife, "You better stop by the library and pick everything you can on rehabilitation. . . . If I am going to have to start walking to get over these things, I don't know how I am going to do it by myself. Maybe you better find a dog somewhere." I was organizing all of this within a matter of a day or even hours.

Was taking charge of this dimension of his rehabilitation programme a way of allaying his anxiety?

> My reaction to a serious problem is usually to try and do something about it . . . because normally if it isn't [serious] I would put it to one side. . . And in some way I think I treated it as a bigger event in my life than I should have. . . . It is serious enough. I suppose that anything that is considered to be a life-threatening event is serious enough. But a more matter-of-fact approach rather than an assault on it.

Martin's enthusiasm for the rehabilitation programme may in part be a reaction to a feeling of loss of control, which he describes as being "close to a feeling of panic." In his professional capacity, he had an efficient support staff, and they functioned to enhance his proficiency. He was, nevertheless, in charge. In the hospital he was no longer in charge. He was told what to do and when to do it; he was expected to comply with the treatment regimen, which was developed by others. He was now in a subordinate role. Moreover, he did not have access to all that was known about his condition. Did organizing his

rehabilitation programme meet a need to maintain some control of his life?

Outward appearances can be misleading. Martin believes that he gave the impression that he was coping well, but this was not so:

> Anybody observing it from the outside would probably have said, "This guy has a healthy attitude towards it. He is already making plans to get out." And all this sort of thing ...what was really going on was great tension, make believing that this had happened and a kind of rejection at a very fundamental level. With all sorts of questions associated with that--"Why me?" All that sort of thing, plus on the other side doing something about it.

A day or two after discharge from the hospital Martin was re-admitted. What was the medical diagnosis? The doctors were not sure what had brought on the symptoms; he was kept under observation for two days and then discharged. How did Martin experience this re-admission? "It was like an after-quake following an earthquake." This experience "did not worry" him in the same way as the heart attack.

Following this second admission, Martin spent a week at the beach with his mother. (His wife remained in the city because their five-year-old son was just starting school.) His mother was there "to keep a general eye" on him. Martin describes his mother as a "clucky hen" at the best of times, and in this circumstance she "became cluckier." Anything he did worried his mother. The atmosphere was filled with tension, although the physical set-up was ideal for rest and relaxation. How did he react?

> I tended to sit in the chair and wonder, "What am I going to do?"... I probably would have been better off going to the Supreme Court Library ... and writing an article on some esoteric point....I would have got absorbed in that, and much less absorbed in myself.

His mother's overprotectiveness made him ambivalent. He felt capable of doing whatever it was he set out to do; but when she intervened, because he respected her views, he wondered if she was right and that he was probably overstepping his mark:

> You don't know what you can do and you think you should try, but then somebody says, "I will do that," and the reason they do it, or the reason they say, or if they say it in such a way, that they have some reservations about whether you should be doing it or not.

Hence his mother's well-meaning behaviour could retard rather than facilitate his return to a normal way of life.

Martin's wife also had some reservations about the jogging activity which he began a few weeks after discharge. His wife, however, was less direct in her approach than his mother's:

> I can remember sensing that my wife worried quite a bit about my taking up jogging, though she never said so; indeed, what she did was to immediately get into it herself. That was interesting because I am not dumb. I mean.

In any crisis situation such as a heart attack, the individual may derive emotional support from family and friends. What sustained Martin during this time? This crisis seemed to foster greater marital cohesion. It brought them closer together. Indeed, "it was one of the great plusses that came out of the whole episode."

> I have a very talented and serene kind of a wife, who seems to take things in her stride. . . . She was her usual serene self.

After Martin returned home from his week at the beach, he and his wife "had several long discussions on what the hell did this [heart attack] mean" and what they would do. What an illness means to the one who suffers it makes a difference to the outcome. Initially, he did not

anticipate any change in his lifestyle, and they both felt he should "get on with things." From his perspective, they were both in agreement. They made a determined effort to pursue as normal a lifestyle as possible. Martin was reassured by the fact that his wife would be able to "cope with either me around or not being around." Later he found out that this was a very difficult time for her. Moreover, sometime later she did tell him he was "irascible." He was not aware of this, and it seems to speak to his self-centered focus and to being oblivious to his change in behaviour.

What long-lasting effects did his heart attack have on the marital relationship?

> I think we are both closer, but much less dependent upon each other in the long run. We are much more people in our own way. . . . It is a better and more honest relationship.

The shock of the heart attack prompted a re-evaluation of the marriage; they stopped taking each other for granted and were able to show more tolerance and consideration for each other. While his wife was very supportive and facilitative in helping him to make the lifestyle changes which he made, over a two to three-year period, she did not subordinate herself to him. He said, "I would not allow this."

While he was less concerned about his wife's ability to carry on, he did worry about the effect that his heart attack might have on his children. He had a young daughter and a five-year-old son. Could he be the father to his children that he would like to be? He liked to do physical things with his children and he wondered if there would be long-term physical consequences.

His associates and friends were also supportive during the crisis

and recovery period. "Friends and associates were very good. . . . The senior partner in the firm dropped by and said, 'Don't worry about these sorts of things.' " When the individual returns to work, however, this may present dilemmas for associates and partners. How should they (associates) treat him (the post-MI patient)? The question of guilt may even surface. Were they in some way responsible? After all, Martin was only twenty-eight years old, and all indicators suggested that he would be very successful in his chosen profession. How would this crisis affect his future?

> There was a certain amount of guilt that got mixed up with it on the partners' side. One of the reasons I had been so busy was because one of my partners, who was a court man, had cancer, and I really had been doing a double work load. . . . I think there were people in the firm who felt it was partly their fault--if they had taken some slack; this might not have happened. But even those who were not affected by that didn't quite know what to make of the situation. They didn't know whether to say to me, "Go get him, tiger," or whether to say, "Take it easy." There was quite a lot of ambivalence in the people I spoke to.

His sensitivity to his associates' reactions could be either facilitative or a hindrance to his recovery. It could become a hindrance if he was to channel his energies into protecting them instead of using every emotional fibre at his command to maintain the fight to survive. It could be facilitative if instead of turning inward and becoming depressed he was able to see beyond himself. Martin was also experiencing a lot of ambivalence, and his associates' ambivalence probably reinforced his dilemma, because he too was wondering how far to go or should he "take it easy." He turned to his doctor for advice and that was not forthcoming. Where did it leave him?

There were times when Martin felt that, while his doctor was an

expert in his field from the medical perspective, he did not understand Martin's feelings and, in particular, what he was grappling with. Although Martin was not trying to abdicate his responsibility for the way he lived his life, he looked to his doctor for advice and guidance on how to cope with living with a heart attack--but to no avail. He could sense the distance, and one day he confronted him:

> "if you don't understand what I am grappling with, then I really don't think you have a handle on what is going on." And he had some difficulty dealing with that.

Martin tried to force the doctor to give him an answer, but his doctor insisted that he find his own solution to the problem. This was very stressful for him:

> I used to get a kind of fluttering, and I could physically sense this. By now I was back in the office, and this used to trouble me . . . and my blood pressure was a bit erratic . . . I was trying to describe to him one day, I remembered saying, "Well, look, Harold, I have to make up my mind whether I should take a jury trial next week. If I take it on, I have to get up on my feet, and I have to stay on my feet for anything up to two weeks in front of a jury." And I said, "It is bloody difficult, if the damned thing starts to go off on me. . . . I am trying to conduct somebody else's affairs and I have to do it as best I can, in a responsible way, and I don't know how to handle this. Do I say, "I can't do it or shouldn't I do it? Or do I just bite the bullet and get on with it?" I was looking for some kind of comment from him and at that stage all I was getting is that, "You will have to make up your own mind on this kind of thing. I don't think you are going to drop dead in your tracks, but obviously you are in a reasonably stressful sort of situation and it all depends upon how you feel."
>
> Despite all the talk about the importance of the client or patient making a choice, I think there are some things that are very difficult for you to make yourself. . . . I don't know enough about the problems involved, and that sort of thing annoyed me for awhile.

Martin was expected to take responsibility for making certain decisions, but because he didn't know enough about the problem," (at least

that is the way Martin saw it) he was in effect making an uninformed decision.

Martin returned to his practice within one month of having his heart attack. He believed that going back to work would be more therapeutic than staying at home, "sitting around and worrying."

> I might as well be worrying about somebody else's affairs and that at least would be some kind of diversion.

Was returning to his old routine, that is to work, a way to distance himself from what had happened?

Returning to work raised other concerns. Martin always wanted to excel, to be the best he could be. He wondered if he would be able to carry out his work role as well as he did before his heart attack:

> I can remember worrying at the time whether I was doing a good job, and whether I could even hope to do a good job under the circumstances.

Two to three months later, he started to get "periods of depression," which lasted for about four months.

> During that whole six month period the time that I got all depressed, and sort of worked my way through that . . . it started with "Why me? What am I going to do?" . . . It's an inward-turning process.

While the doctor prescribed an antidepressant, Martin felt that he "fought his way out of it." Once again he channelled his energies to overcome his depression; instead of watching television, he wrote a couple of articles in the evenings to keep himself occupied. He was a keen fly fisherman, so he did a lot of that. He was determined that he would not live like this (depressed), so he started jogging. Would he survive this physical stress?

> I thought to hell with it. I am going to go for a run. If I fall over I fall over, but I am sure as hell not going to stay like I am. So I put on a pair of tennis shoes. I guess I ran a half to three-quarters of a mile, and I didn't fall over. And I didn't even feel much out of breath. Each battle is a small win. . . . You slowly fight your way through it.

Martin's determination and his will to transcend his situation saw him overcome a heart attack and the ensuing depression. Each setback became a challenge. Moreover, his depressive episodes provided insights into what others suffer. In his professional capacity, Martin often read medical reports which stated that the client was depressed; the word was devoid of meaning--now, he knew what that meant. "I did not understand what the hell that meant [depression]. As it turned out, it was a first-hand educational experience."

The occurrence of a heart attack is in itself a strong motivator for the individual to change and/or modify certain lifestyle behaviours. Unlike many post-MI patients, Martin has been able to maintain the changes which were self-initiated and were instituted over a two to three-year time span. The first change was that he quit smoking--he had smoked three packs of cigarettes per day. Another change, which was less immediate but which was instituted early in his hospitalization, was in his diet. On this diet he lost twenty to twenty-five pounds, and over the years he has tried to maintain his ideal weight. He began jogging on a regular basis. At the time of our conversation (1985), Martin was forty years old. His plan was to run a marathon for his fortieth birthday, but he had a knee problem so he was not able to meet this objective. He cross-country skis, regularly plays racquetball, and he downhill skis (at the intermediate level).

He took up downhill skiing in recent years.

In the summer he goes back-country hiking and climbing. This is indeed a change:

> Not long after my heart attack I didn't like going far away from my home base. This is a sort of psychological dependency . . . on being relatively near the people you know, to doctors, and hospitals, and all that sort of thing. . . . The fact that I am prepared to march off some miles into the back country without literally putting my mind to the matter at all. . . . whatever is in there is long since gone.

Before his heart attack, Martin used to be in court until 11 a.m., would drop into the office to see what "disasters" there were, go to the club for supper, and then back to the office. "It was an 8 a.m. to 12 midnight" day. Martin did return to the practice of law following his heart attack, although he made some changes in his routine. Later on he decided to give up the courtroom for academe.

As time marches on, it becomes difficult to know which aspects of the individual's present life are directly related to the heart attack and which aspects are due to other circumstances. There are times when Martin feels "low" and he wonders if this feeling is related "to what happened in earlier years." There is one dimension, however, that is directly related to his heart attack and which in all likelihood changed the course of his life; that was his decision to leave his native land and "to work overseas." This is when he decided to give up the courtroom for academe.

Martin says that he was the "classic Type A personality": there was always more to do than time in which to do it. Life was a constant struggle with the clock. This was the most difficult element of his behaviour in which to effect a change:

> That, of all the battles to overcome, and battles is putting it lightly, above all the problems to overcome, that's the one that still lingers with me. I still have to fight that.

It was easier for him to overcome his cigarette habit, to lose weight, to maintain a regular exercise program than to overcome his time consciousness.

The crisis of his heart attack seemed to have provided the opportunity for him to look at himself, to come to terms with himself, and he consequently discovered the emotional aspect of his being. He is not just an efficient, productive, intelligent, task-oriented being whose life is ruled by schedules and procedures. In this way he is able to empathize with women whose world traditionally is the world of human emotion--love, attachment and anxiety and a world which is more people-oriented. He concludes that after his heart attack he is "a vastly different person than I was before in terms of a more integrated personality." What does he mean by this?

> One just faces oneself and what one is doing, and doing with one's life and that I think is an honest kind of thing. . . . Before and for awhile afterwards I really had a lot of trouble in finding fault with myself. Fault is the wrong word; just recognizing myself. . . . Now I do not. If anything, I have gone the other way.

Now he feels that he is more direct and open, a quality which he finds in women, and consequently he feels that his interactions with women, whether in the work place or in a social setting, are more authentic:

> I can just walk in and say I am completely pissed off about this. I can be quite direct about it. And you know we sort of deal with that.

His interests have also diversified. He said, "I now have a much broader view of life and my place in it."

Today (twelve years later), he rarely thinks about his heart attack:

> It doesn't trouble me in the slightest . . . I climb, I ski, I do heavy work around the place. It doesn't ever cross my mind; and on the emotional or more stress-laden side, although the things I do are not quite directly as stressful as full-fledged court room combat would be, I still teach and I suppose there is some stress in that.

Martin is also involved in a number of national committees and often speaks at academic conferences. Now his primary interest is research. In order to pursue this interest, he has declined a number of top level academic appointments and an opportunity to join a prestigious law firm in Eastern Canada.

There are moments, however, when Martin remembers that he has had a heart attack. One such moment occurred recently when he discovered that to increase his life insurance benefits he would have to pay a "ridiculous premium." Sometimes when he is about to lift "something <u>really</u> heavy," he said, "it has flashed across the back of my mind on the odd occasion. I wonder if I should be doing it."

Each of the reconstructed narratives allows us to look at the particulars of a lived experience. And in each person's narrative we can detect a certain pattern of meaning, a thematic concern. With Mulder we saw at the onset of his heart attack his puzzlement over the pain, and subsequently how his life is organized to meet his body's need for sleep, rest, exercise, relaxation, and tension management. Exercise has become an integral part of Radowski's life; daily he puts his body through its paces. Nevertheless, he lives with the spectre of

his mortality. For both for Mulder and Radowski, the experience of the body takes centre stage.

Singh lives his commitment to his family. Having time for his family is more important to him than getting ahead in the work world. He is less achievement-oriented. Work is no longer the centre of his universe. Singh's narrative speaks to his preoccupation with human relationships. He has a deepened relationship with his spouse and children. Enjoying life is important to him--it means finding the time to live fully.

Woytowich is living a second chance. He has learned to take things in his stride. It might take him longer to accomplish his goals but he perseveres. What we see in Shaw and Woytowich's life is a focus on temporality--a questioning of what to live for, a re-thinking of goals and worthwhile present involvements.

Hamilton has created a space in which he maintains control of his life. Life has returned to normal; that is, he is able to do whatever he wishes to do. Yet forgetting is never fully realized. Martin is living a different life. He left his native land and channelled his career in another direction. He has found a place where he pursues his ambitions and maintains control of his life. He marches to his own beat. At the risk of forcing the issue, we might say that both Martin's and Hamilton's stories are oriented to the spatial dimension, to different ways of being-in-the-world.

CHAPTER 5

CORPOREALITY: THE BODY LOSES ITS TRANSPARENCY

Introduction

Pain draws attention to the body. On the train, Mulder became aware of "a very severe pain" in his chest. In fact it was so severe that he thought he was going to die. Radowski was driving home from work when he experienced a pain in his left shoulder. The pain intensified and was accompanied by other symptoms. The intensity of the pain distracted both Mulder and Radowski from their engagements in the everyday lifeworld and focused their attention on their bodies. Both took their bodies for granted until they became impediments to their projects. When the body becomes an obstacle, it loses its transparency. Thus we no longer "extend through it without attending to the embodiment itself" (Rawlinson, 1982, p. 75). The body is subsequently experienced as distinct and opposed to the unity of the mind and body.

As the body emerges as a separate entity, it is no longer enabling. If pushed beyond its capacity, it revolts. Even crossing the street was an ordeal for Mulder; the lights would change before he reached the other side. But he could not walk any faster--to push his limits would be to risk a recurrence of chest pain. Recall that when Radowski was over-zealous in his pre-game warm-up, he was fatigued for

the rest of the day. In order to avoid the consequences, the post-MI patient begins to listen to his body and to respond accordingly.

Listening and responding to the body means the body's needs are determined, and measures are taken to enhance its capacity for functioning. Radowski daily puts his body through its paces in the hope that this regimen will make a difference; in fact, he sees exercise as a "last chance." Mulder works diligently at meeting his body's needs.

Separation of the Mind and the Body

For many MI patients, the pain is a different kind of pain, unlike any pain ever experienced before. Hamilton related that he had "had chest pains many times before, but this pain was worse than usual." The pain has an oppressive, death-like quality, and it mimics other sensations, "as if someone were drilling me" said Radowski. Martin spoke of a searing quality, "as if I had a hot poker up the middle of my chest." Shaw experienced a crushing impact, "like someone standing on my chest, or pushing on my chest very hard." The source of the pain, which is at first experienced as an external force, enters the body.

The pain not only persists but it may gradually intensify and spread to parts of the body far removed from the site of origin: "It was quite a sharp pain. . . . The pain . . . went out in my arms," said Hamilton, and Singh recalled, "It went up my shoulders out to my arms." The pain threatens to engulf the individual, it holds his attention, and he is imprisoned by it. There is "a terrifying seepage of

strength" (Lear, 1980, p. 13). It depletes energy, as Mulder discovered: "On arriving at my friend's place, I was very tired." For Lear, "the pain was the sensation of losing all power." He felt that "life juices were draining from his body" (Lear, p. 13). Furthermore, the pain persists despite the individual's attempts to alleviate it.

The real meaning of the pain may not be immediately apparent. As it persists and is accompanied by other symptoms that are part of the pain experience, however, the situation changes. The following acquaints us with images of struggle that recur in the words. Hamilton said, "You sort of feel you have to breathe and you can't breathe, you can't get no air." Martin felt he was "on the verge of losing consciousness." Woytowich wanted to tear his chest apart: "I felt . . . if I could only tear it open and let some air in, I would be all right."

Attention shifts from the activity in which the individual is engaged to his body, because the body is a constraint to realizing his projects; it is no longer enabling.

Experiential characteristic one: The pain disrupts the MI patient's engagement in the world and forces him to focus on the body which can no longer be taken-for-granted.

Pain, however, has a protective or self-preserving value since it serves an important role in the body's survival. Cousins' (1981)

refers to pain as a "gift" (p. 107). Without this gift of pain, our bodies could be subjected to severe physical harm as our capacity to endure would extend beyond the point where it would be impossible to maintain the body's integrity. Consider the consequences of placing a hand on a hot plate and keeping it there because of a decreased sensibility to pain. Cannon (1932) points out that while there are exceptions, "the general rule holds, that pain is a sign of harm and injury . . . it saves us from repeating acts which in the end make an end to life itself" (p. 229). Moreover, the importance of pain in MI is seen when as Rutishauser (1984) points out:

> The existence of the syndrome which has been variously termed "silent," "painless," . . . "asymptomatic" myocardial ischemia can no longer be denied . . . it is well known that . . . myocardial infarction can occur . . . sudden death sometimes being the first manifestation. (p.1)

How often do we think of pain as a gift? Pain is more commonly "regarded as a polar concept of pleasure" (Angeles, 1981, p. 202). Pain is to be avoided while pleasure is to be sought. Pain is regarded "as a negative and negating element in human experience and conduct" (p. 202). Thus pain implies a negation, since it underscores our vulnerability and the transience of life. This is exemplified by Mulder's feelings and perception about his pain: "I knew that something was really wrong. . . . I really thought I was going to die." There is the experience of a premonition of death.

The body's emergence as a separate entity begins with the pain experience and is further enhanced by the tiredness. Levy's (1981) subjects reported "an extraordinary loss of vital energy" (p. 158). And Foster (1984) tells, in his autobiography, of a pervasive feeling

of tiredness "reaching into every extremity, every nook and cranny" (p. 219). Almost every participant in my study talked about this loss of energy. It is difficult to begin much less to complete any projects because "you tire easily . . . you are too played out" said Radowski. And Singh recounted, "I would shave half my face and I would have to rest." Yet the individual may not want to sit and vegetate. There are things to do. He feels he can do them; but as soon as he begins, this tired feeling creeps upon him like a fog. It enshrouds him, and he is as Woytowich sighed, just "too pooped" to do anything. So once again the post-MI patient attempts the "long" return to bed or to his "easy" chair to recuperate. He is aware of a frightening pounding in his chest. He must rest. Gradually his heart slows its pounding. How short is his activity span! Is it worth trying again?

In the hospital, once the pain is alleviated, physically the MI patient feels rested and this is translated into being back to normal. The reality, however, proves this to be an illusion. Returning home, he quickly discovers that simple activities of everyday life tire him and this creates self-doubt and anxiety. Schoenberg and Stichman (1974) capture how the post-MI patient may feel when they ask: "How can simple everyday actions tire or weaken any but a desperately sick and debilitated man?" (p. 153). Moreover, he may be more tired when discharged from the hospital than when admitted. (p. 153)

It would be doing what comes naturally "to take it easy," to give up trying. Why get up in the morning and get dressed if he is going to spend most of the day reclining in bed or in a comfortable chair? Getting up and getting dressed means that he plans to engage in some

activities, but he is too physically incapacitated to do so. Why engage in this ritual that belongs to another time and another place? It would be easy to become resigned to his deficiency in vitality and start that downward spiral to invalidism. Why waste time and effort if his plans are constantly thwarted because of this feeling of total exhaustion or near exhaustion? Hence getting up and getting dressed demands will power; it becomes a struggle.

Before he leaves the hospital, the MI patient is reminded to take it easy, to slow down, to avoid heavy lifting, to take short walks, to take the stairs slowly with pauses to rest. This advice seems unnecessary because he quickly discovers this is what he has to do: "If I walked up the stairs . . . or around the house I would get very tired for the first few months," remembers Singh. His body revolts if the post-MI patient exceeds his capacity. He becomes very aware of his body. "When you begin to move around, your heart rate starts jumping, going up and down," Radowski said. "You have to watch what you do for the first while."

Experiential characteristic two: Excessive fatigue and specific body responses force the MI patient to objectify the body as he is encumbered by it.

What the post-MI patient is able to do is limited by chest discomfort if he overtaxes his healing heat. We learn from Mulder that the

physical limitations may create the sensation of an accelerated aging process: "I tried to walk slowly in the beginning. I really felt old because I could not walk normally."

Even activities which used to facilitate relaxation, such as watching television are tiring. Reading is tiring. Visitors are tiring. "In the beginning it was too much," said Mulder. "I did not want them [visitors]. I was really tired. That is one of the pervasive feelings is that you are tired." Walking is an effort. At first the post-MI patient's feet feel "wobbly" and his heart begins to race. He is not only tired, he is also weak.

The body appears to play games with the mind; since rest gives the body time to recuperate, the post-MI patient feels fit and he begins planning his next move. His mind spurs him on, yet "what an inaccurate gauge of the body the mind can be" (Mullen, 1984, p. 107). It is time to try again; as he begins to traverse a distance of a few meters, it is magically transformed into a few kilometers. Is this the same distance that he once crossed without thinking about it? Now it is like participating in the Boston Marathon. It depletes his energy but it does not give him that feeling of accomplishment. Moreover, later he may discover that there is an underlying cause for his tiredness, he feels vindicated, but he may give up trying, like Woytowich:

> After I had the tests it was worse, because then you knew you couldn't do it. You would get up to do something and you would remember you only had a small percentage of your normal activity left, that there was no way you could do it.

There are other ways in which the body frustrates one's objectives. Singh's plans to pass the time in the CCU by reading were

thwarted because he "couldn't hold the book for very long." For Singh, reading was difficult because he was too tired to hold his book; his attention shifted from the printed page to his body which was no longer enabling. He would have to terminate his project because his body was uncooperative.

The body loses its transparency when it becomes a source of impediment. It is experienced as distinct and opposed to the unity of the mind and body. The body presents itself as a separate entity. Normally:

> We extend through it without attending to the embodiment itself. For example, ordinarily in reading I am directed toward the words which stand out meaningfully for me there on the page. My eyes and my seeing are themselves not seen until that bodily capacity fails me; that is, only when my eyes hurt do I become aware of my embodied seeing. (Rawlinson, 1982, p. 75)

Experiential characteristic three: The body, in so far as it is experienced as an obstacle, loses its transparency for the MI patient.

The body may be seen increasingly to be an obstacle "to the point of appearing no longer passively resistant but actively hostile" (Gadow, 1982, p. 93). Such was Mulder's experience:

> Normally . . . I am a brisk walker. Half way there I thought I was not going to make it, so I stopped a car. . . . A man stopped and I said, "I want to go to my doctor but I am not sure I am going to make it."

The loss of the body's transparency is ontological as it affects the post-MI patient's being and his world. He learns to listen to his

body, his body sets limits, he no longer takes for granted what he had hitherto taken-for-granted. His body also sets limits upon his interaction with others and with his surroundings.

Listening to the Body

The loss of the body's transparency compels a response since the mind and the body are at odds with each other. What constitutes a response? The response emanates from the constraint and necessitates listening to the body. Listening to the body means that the post-MI patient turns his attention inwards, he takes stock of his needs. But there is a double movement here. As he turns his attention inwards, he is at the same time distancing himself from himself, because in order to take stock he must distance himself from his body.

Each change of milieu represents movement in the direction of returning to some semblance of a normal way of life, but ironically each step is beset by feelings of uncertainty. Moreover, the tired feeling surfaces again and again. Returning to work is a most significant event, although at first the post-MI patient may be required to curtail his working hours. His body finds it impossible to work full-time. Hamilton remarked, "I didn't go in for a full day. . . . I went in in the mornings and I came home in the afternoons. I would be VERY TIRED." Mulder recalled, "As I went back to the Academy I went back for a few hours each day, then increased. . . . I had a couch and I lay down every afternoon for an hour."

The post-MI patient's body now occupies centre stage: "it dictates

prohibitions and destroys possibilities" (Gadow, 1983, p. 93). In other words, it thwarts his ambitions and it circumscribes his world. Moreover, life itself now depends upon meeting the body's needs. They can no longer be subordinated to the will. He must listen to his body, he must come to know his body, and he must acquire new ways of responding to his body. Singh highlighted this when he said, "If I go outside in the summer to cut the lawn . . . as soon as I get tired, I quit. [Something he did not do before his heart attack; once he began the task he completed it, no matter what.] But I don't like to quit." Being responsive creates a tension between desire and physical capacity.

Tiredness, like pain, is a protective mechanism. It is the body's way of saying it has had enough, and consequently it allows for preventive action. If, however, the individual fails to heed this caution and persists in his project, he experiences chest pain or chest discomfort as Shaw discovered: "If I push myself too hard, I really do notice it . . . I get pains through here [he passes his hand across his chest wall from left to right]. I can feel it. I just know that it is time that I stopped."

Experiential characteristic four: In the experience of extreme fatigue and alarming pain, the post-MI patient has ongoing encounters of absolute corporeal limits.

Failure to take corrective action, that is measures to relieve tiredness, may result in chronic tiredness that progresses to excessive fatigue. As Kavanagh (1980) puts it:

> Both fatigue and irritability may be the result of a return to the old driving, overcrowded lifestyle, with its business and financial worries, impossible work schedule, and absence of physical activity and recreation. In short the very set of circumstances which probably triggered the initial acute attack. (p. 196)

Fatigue heralds a need for the post-MI patient to reappraise his lifestyle. He may be overdoing it and he must adjust his life accordingly.

The human heart is considered to be the centre of life and vitality (Levy, 1981) and the imagined source of emotions, as contrasted with the brain--the source of reason. The heart is the force that gives life and energy to the body. Mulder provided an example of the meaning of centrality when he said, "It is one of the most vital organs, and every aspect of your being is affected by it." Thus if the heart is affected, change is inevitable; a heart attack changes the way you are and the way you act.

The heart attack is viewed by the post-MI patient as an occasion to evaluate his circumstances. At the time of the event it seemed "to come out of the blue." It is difficult to live with discontinuities; hence, he tries to make sense of it. He seeks causal explanations for his illness, and the most frequent ones are work-related. Mulder said, "I was working too hard, much too hard. Doing scientific work, working with students and running the Academy." Singh recalled working long hours with very little time for family life: "I worked hard; I never left at 4:30 p.m., it was always 5:30 p.m. . . . My weekends were not

my own. I had phone calls all hours of the day and night from the field crew." Martin had additional responsibilities when one of his partners suffered a severe illness. He was in effect "doing a double work load." Radowski suspected the environmental conditions of his work place: "I think it could have been the conditions under which I was working. . . . Where I worked it was dusty . . . all the dust from chemicals."

Prior to his heart attack, the post-MI patient may have abandoned himself to work: he was consumed by work, and it enslaved his freedom. That has changed, and now he wishes to maintain some semblance of control. This generates conflict between his desire to live a normal life (work is a dimension, but not the only dimension of that life) and submitting to the demands of the work place which may increase his vulnerability to re-infarction. As the demands increase he may resist them, but in resisting he creates tension between himself and his colleagues. This was Mulder's experience: "I learned to say 'No'. . . . Why should I do so much? People are really making too many demands on me. . . . It bothers me because I think I disappoint them sometimes, but I cannot help it." Is it easier to say "No" to what the individual perceives as unreasonable demands after having a heart attack? Does the individual place less emphasis on the "public self" and more on the "private self" (Hall, 1984, p.10)? Is he able to place his own welfare ahead of others?

Listening to the body may necessitate a change in the post-MI patient's daily routine. Recognizing risk factors and acting to minimize them, he must do things differently. This translates into a

change in lifestyle, and often involves making many sacrifices. Is he prepared to make these sacrifices? Changing his lifestyle may be a small price to pay for being able to return to a productive life. In their study of over two hundred MI patients, Wicklund, Sanne, Verdin, and Wilhelmsson (1984) found that:

> Many patients were satisfied with their present life situation in spite of considerable changes in everyday life. Survival and health probably had greater significance than other needs and overshadowed the negative consequences of the MI. (p. 62)

The regimen is worth noting as it stresses the physical state: it directs attention to certain physical needs. The post MI-patient must maintain his ideal weight, no mean task for the person who has been overweight for most of his life. Some, however, are successful as Hamilton's comment illustrates: "I was up to two hundred pounds [he is about five feet nine inches tall] to start with; now I am down to one hundred and eighty pounds." The post-MI patient must get adequate amounts of sleep and rest. The body's response to a lack is immediate and may be so incapacitating that he is likely to heed this requirement. Mulder pays particular attention to his need for sleep: "I sleep better. Once in awhile I will sleep one night not enough, too short, but then I make sure the next night I get enough sleep." If Hamilton feels tired during the day, he rests for a few minutes on the chesterfield installed in his office after his heart attack. He no longer forces himself. The need to quit smoking may be problematic; some people become perpetual quitters. The post-MI patient must learn to relax and to remove tensions from the body; often he is told to exercise regularly, unless contraindicated.

Experiential characteristic five: The post-MI patient must learn to tune the functions of his body in mechanic-like fashion.

Being attentive to the body's aches and pains is also a means of listening in a diagnostic way to the body. Chest pains, however, are fairly common, the result of strain on the intercostal muscles and nerves. The difficulty arises in differentiating between those which can be disregarded and those which require medical attention (Nolen, 1976). In any case, each discomfort must be assessed to determine which is innocuous and which must be heeded. After his heart attack, Mulder became very sensitive to chest pain:

> If you get a chest pain, you think maybe it is. . . I remember one evening I was afraid I was having a heart attack. I was very weak, feeling very bad again, and I phoned my doctor. . . . She did an ECG. She said, "You don't have a heart attack." I was satisfied.

Hamilton also became sensitive:

> After I had the heart attack, there were lots of times I went back to emergency or to the doctor's office. Any little pain, I thought, that's it.

The problem is complicated when the individual has a condition with symptoms similar to those of a heart attack, as is Radowski's situation. When he has "chest pain" he takes a nitro. If the pain persists, he assumes it is his hiatus hernia and continues to do whatever it is he is doing. Chest pain which is not alleviated by Nitroglycerine however, may be indicative of a heart attack. In any case, it warrants

medical attention.

Experiential characteristic six: For the post-MI patient, survival and health depend on being attentively attuned to the meaning and significance of each symptom of physical discomfort.

When the body loses its transparency, it is thought of and experienced differently. The individual becomes more aware of his physical state. There is a heightened sensitivity to bodily discomforts. His physical state, to a large extent, determines what he will do and what he will not. Listening to the body is a way of tending it and caring for it.

The Objectification of the Body

The objectification of the body emanates out of a heightened sense of awareness of bodily limitations. "The experience of the body . . . as object emerges out of the . . . encounter with limitations of being encumbered and prevented from acting without constraint" (Gadow, 1982, p. 92). The body and its functions are no longer taken-for-granted. The limitations may be viewed as a problem to be solved; hence, the post-MI patient seeks to right the wrong. This is congruent with the physician's approach. As Gadow notes, "the body for the clinician, may be an object to be examined—or more abstractly--a problem to be solved" (p. 86). The body must be assessed by various means including

technological: "It is auscultated, tested, and palpated by the physician" (Van den Berg, 1966, p. 66). What happens, however, if there is no solution and the post-MI patient has to live with "the problem"?

The body becomes something removed; and the physician, as mediator between the mind and the body as object, is expected to share his knowledge and to assist the individual in setting limits, as Singh demonstrates:

> He [the doctor] came in, he examined me and left. He never told me I was improving, getting worse, nothing. . . . Even when I went to his office afterwards, I would go in there, he would take my blood pressure, sound me, no words. . . . He didn't even tell me what my capabilities were, whether I could push a car or shovel snow.

The body is subjected to various tests, such as coronary angiography which many of the participants underwent. This test reveals where, and to what extent, there are blockages in the coronary arteries. It is a procedure which permits one to see one's coronary arteries: "He kept staring at the screen. Now he could see one of his coronary arteries . . . and yet even now, a kind of detachment" (Lear, 1980, p. 130). Thus the angiogram is another way of coming to know the body as an object through the medium of a highly-sophisticated technology. Shaw recalled viewing the angiograms with his doctor. "He [the doctor] says . . . here's this one and here is that one [referring to the coronary arteries] and this one is seventy per cent blocked." The post-MI patient may even possess one of the films (angiograms) which he carries around in his wallet.

The post-MI patient may be subjected to one or more stress tests as a means of assessing the body's functional capacity. The body is

put through its paces, and he waits to find out how well it performed. Like any other mechanical object, it is pushed to determine its limits--performance is the thing. How well will the body respond? Often the post-MI patient is reassured by a favourable response to the stress test (Acker, MacMorran, Friedlob and Wade, 1982). Furthermore, it could shape his expectations and attitudes regarding physical activity, as it builds his self-confidence.

In addition to routine assessments, the post-MI patient addresses certain concerns and confronts certain limitations. He puts, where applicable, varying degrees of emphasis on diet, exercise, sleep, rest and relaxation; in short, neglect of the body is replaced by attention. Physical conditioning, for example, is no longer disregarded. If he exercises regularly, he looks for signs of progress. With the passage of time, he expects his endurance to improve. Is he able to sustain increasing levels of physical effort? He monitors his pulse rate: is it decreasing as it should? How does his heart respond to an increasing work load? How will his body respond to the next stress test? As he exercises, he pays attention to his body. Chest pain or chest discomfort is not to be ignored. If it occurs, he stops or slackens his pace; he wishes to put his body through its paces but not to overdo it.

Experiential characteristic seven: As the body takes on meaning as an object the post-MI patient finds new ways of doing.

There are times, however, when he may decide to exceed the prescribed limits. Why? What makes him force his body to do more? What is he out to prove? Is he afraid of becoming a "cardiac cripple," of slowing down to a complete stop with nothing to look forward to? Mulder's fear of invalidism made him do more:

> You cannot be too soft on yourself. I have seen some people with heart attacks who are too soft on themselves--they don't recover, they stay as invalids for their life. . . . I always went as far as I could and then a little further.

Recall also that becoming an invalid was Woytowich's greatest fear:

> By the time I was ready to go home, they [the health care professionals] had to tell me not to do things.

Now Singh seems to feel that he is the best judge of what he can do:

> Right now the only limitation is shovelling snow, lifting heavy things. . . .I still shovel snow; I still feel I can do it.

Pushing his limits for the post-MI patient may also be a function of being able to look at his body with detachment, to perceive it as an object which can be manipulated and its possibilities probed. Perhaps he wants and needs to know that he can <u>do</u> and perform at a higher level.

When the post-MI patient exercises, he enters another time and space; he is in tune with his body. His body takes centre stage, consuming his attention. He is aware of how his body feels, and he discovers a pace that is best suited to his body's needs--a pace that hovers near to his target heart rate. As his physical capacity improves, he may have to adjust his exercise prescription to attain and maintain his target heart rate--maybe walk and jog, or walk faster,

whatever. With time he is able to locate his pulse and to calculate it without much effort (although some take longer than others in mastering this skill). In any case, he leaves his everyday concerns for awhile, and his energy is concentrated within. Radowski muses, "Well, you sort of relax. It seems as though you sort of forget about everything when you are doing it. Just happy to be doing it."

This feeling of well-being provides the incentive to exercise on a regular basis. "If I miss a day or two, I really don't feel right," said Radowski; Hamilton said he "feels good" when he exercises. If one or two sessions are skipped, however, re-starting is difficult. Ironically, it is when the post-MI patient skips sessions that he realizes the beneficial effects of regular exercise. This became apparent to Shaw when he missed several sessions:

> I feel much better if I do. . . . If I don't do it, like during the summer I got busy, I would say, "I am too tired today." In September I was very busy, in October the workmen were still renovating the gym. . . . Now [December] I have been back at it for three weeks and I feel much better.

The competing interests of job, family, and other activities provide a never-ending list of excuses. It is even more difficult to maintain the momentum when you exercise alone. It requires a commitment which Mulder has made: "I always walked, but did not do it regularly. Now [twelve years later] I do it everyday and I feel good."

As the weeks pass, the post-MI patient's endurance improves and this is tangible evidence of the benefits of exercise. He is able to sustain increased amounts of physical activity. Hamilton recalled:

> After my heart attack it [stair climbing] was a little hard to do. I petered out. But as I got working with my exercise it just improved. Within the last few years it really improved with jogging. That makes a lot of difference.

Today, Mulder walks daily without any discomfort. In the beginning he "had to stay still at two hundred meters. . . . It [chest pain] came back," but if he stayed motionless the pain abated.

Exercise not only builds physical stamina but it promotes relaxation by decreasing tension. So other benefits accrue to the body through exercise training. When Mulder feels stressed, he goes for a two-hour walk, which he finds beneficial. Once Woytowich had "a hard time coping with stress"; since starting the exercise programme, he copes a lot better. He said, "I used to have a short fuse."

Depression almost universally affects people who have had a heart attack--initially when they realize that their lives are in serious jeopardy and/or later when fears of invalidism surface. Martin considers jogging the antidote for his depression. He started jogging out of sheer desperation:

> I can remember the day I decided to start running. . . . I thought, dear God, I am not going to live like this. . . . I thought to hell with it. I am going to go for a run and if I fall over I fall over . . . I guess I ran half a mile, three quarters of a mile, and I didn't fall over. And I didn't even feel out of breath.
>
> then I became quite obsessive about it. I have been running ever since. [It is now twelve years.]

He subjected his body to a stressful ordeal and he came through.

Experiential characteristic eight: The post-MI patient may discover the benefits of exercise while being attentive to the body's response to it.

The experience of the body as object, however, is qualitatively different from the post-MI patient's experience of other objects. He is not merely an object among objects. He is intimately related to his body, unlike his relationship to other objects; hence, he cannot apprehend them in the same way. The object that his body is pervades every aspect of his being--his body engages him in as much as he <u>is</u> it--the body as object.

CHAPTER 6

SOCIALITY: A BEING TOGETHER WHILE BEING APART

Introduction

Singh was touched by the caring which so many people showed for him. Some of them were total strangers. He discovered his life had meaning for others, that they were with him in his misfortune. Recall the "prayer circles" organized by people of different religious persuasions.

Singh's heart attack seemed to make him more sensitive to the other's presence, and in turn he saw and related to the other in a different way. There was a feeling of closeness. He could reach out to the other and in so doing discovered the other was there for him. His wife and five-year-old son spent many hours at his bedside while he was in the hospital. It was as though their lives were put "on hold." The experience deepened the relationship between himself and his family.

Before his heart attack, his life was organized around his work situation; now it is organized around his family life. He wants to be a father to his children. He is deeply involved in their extracurricular activities. There is a special bond between father and son. His son is particularly sensitive to his father's physical well-being and

acts to minimize physical stressors. Singh's time with his children is sacrosanct.

Sometimes, however, the other's well-meaning intentions may actually distance the post-MI patient from himself and his world. Singh's family still scrutinize his physical activities and intercede to limit the time he spends doing what they consider to be strenuous tasks. He said, "Everytime it snows I go out there. I wouldn't do the whole job. . . . They are more upset than I am. If I have been going for ten to fifteen minutes, my son comes out and says, 'Aren't you tired, Dad?'" Singh, however, believes he knows what he can do, and he does not take undue risks.

A Reorientation to the Other

Discovering Those Who Care

The heart attack may jolt the individual into awareness of his mortality. If he survives, he lives with the knowledge that re-infarction or even sudden death is a possibility. This knowledge is shared by others, and it has special meaning for those closest to him, for example his wife. Prior to the heart attack, husband and wife may have taken each other for granted. The heart attack may force the post-MI patient to take stock of his relationship. This life-threatening situation has the potential for bringing about a close relationship or for splitting the relationship apart.

For Martin and his wife, it became the occasion for a coming to-

gether. With her he was able to explore "what it [the heart attack] all meant." In the coming together, his wife was in tune with him in his world. To be in tune with him she was able to enter into his world and see it as he saw it and as if it were with his eyes (Mayeroff, 1972). She was supportive of his desire to return to a normal way of life as soon as possible. She did what she could to facilitate his projects (recall her role in assisting him to plan his exercise rehabilitation programme). She was there for him, not only in a physical sense; she was present in her wholeness to his presence as a whole being. His wife gave him her undivided attention and was able to focus on his needs. Because she knew him, she could support him in his undertakings rather than oppose him. Admittedly, her actions might have seemed inappropriate to others as Martin mused:

> I think people need to be turned outside themselves; certainly that would have been true for me. Hilda probably understood that better than most people. I think that people used to say to her once I had started back [to work], "Good God, how on earth can you stand this? And what's more how can you let him do this?" But she understood more than most people. And that was in some way therapeutic.

When the post-MI patient's wife is supportive rather than opposed to his projects, he is able to get on with living. Support is liberating, and it also creates an atmosphere of trust. It fosters his existence as an independent agent with the ability to interact with his world on his terms. He can be himself. Moreover, "trusting the other is to let go; it includes an element of risk and a leap into the unknown both of which take courage" (Mayeroff, 1972, p. 21). But letting go is not synonymous with abandonment. She remains there for

him.

The post-MI patient is moved by the other's response to his predicament. Mulder was touched by the unexpected visits from his students: "Some students came . . . that I really didn't expect to visit me. You know with students . . . you don't share with them your private life, but then you see what you mean to them." Shaw was most appreciative of the month's vacation in Maui which his eldest son organized: "He got me a first class ticket. That is a great extravagance. I never travel first class, but it was very nice. Everything was well-organized."

The post-MI patient discovers caring in the patience which the other demonstrates. Singh's five-year-old son spent hours at Singh's bedside in the CCU as well as on the ward. Sometimes he sat in silence working on his own projects; at other times he conversed with his father. But he was there--he was present for his father. Being patient is not simply giving time and space. More accurately it is being with and being for. Patience is enabling.

Experiential characteristic one: The post-MI patient experiences caring when the other is <u>with</u> him rather than merely next to him.

<u>Seeing and Relating to the Other in a Different Way</u>

In the coming together, the post-MI patient sees the other in a different light. The coming together, as it were, illuminates. It

seems as though his heart attack makes him more sensitive to the other. At the same time that he experiences caring in the other, he also experiences the other in a different way. He discovers "qualities" that he never saw before. Martin's wife seemed so strong, so capable and so confident:

> I have a very talented and serene kind of wife who seems to take things well in her stride. . . . I can't speak too highly of Hilda during that period. . . . I wasn't left with any doubt as to her being able to cope with either me around or not being around.

It was reassuring to know that she could "cope" if need be. Singh had a similar experience:

> I really got to admire her [his wife]. She stood up through this thing like I don't know. She must be really strong. To look after two kids and to look after me. . . . Some people may have walked out on me.

Singh was not overpowered by her strength. It was comforting. This strength that she radiated was so important when his whole world seemed to have collapsed. Her strength was a stabilizing force in what at first seemed like a rapidly-changing world. In his loss, he experienced a gain. Her strength empowered him; it gave him the wherewithal to muster his forces.

Experiential characteristic two: The post-MI patient's experiencing his wife's caring attitude may become the occasion for discovering "qualities" in her that he was oblivious to before. These qualities may be enabling if they give him a sense of security.

Singh's wife stood by him amid the general upheaval surrounding his heart attack. She did not let him down when he needed her most. He could count on her. Moreover, she endured his mood swings. But he never really knew how she felt throughout the ups and downs of the adjustment period following his heart attack: "We never discussed it, how she felt or anything." He may have sensed this was a difficult time for her, but why the silence? Was he afraid that talking about the experience would raise doubts in her mind about continuing the relationship? Would it distance them in some way if she were to stop and reflect upon what had happened? Are some things better left unsaid? Would talking about it come too close to the "core"? Would it open a Pandora's Box? What purpose would that serve? There seemed to be a tacit understanding that this territory was not to be explored.

Martin experienced a closeness in the marital relationship which was not there before, although there was a history of a good relationship prior to the heart attack. In fact, Martin describes this closeness as "one of the plusses that came out of the episode." The crisis emerges as their crisis rather than his. As "their" misfortune it unites them in their desire to deal with it. Their energies are channelled in the same direction. But in this closeness they do not lose their separate identities: it is not the merging of identities. In fact, the strength lies in their ability to be at once separate and together. Closeness is not to be confused with dependence. Instead their capacity for closeness is rooted in their capacity to be independent. "We are very much people in our own way."

What we see in the closeness is a fusion of an awareness and an

affirmation of the other as a separate human being; at the same time there is an ability to reach out to each other and to bridge the gap between them.

Living his Commitment to his Family

Caught up in the work world, Hamilton had very little time for his family--they "came second." Work became a way of life "rather than a way of making a living" (Montague, 1975, p. 3). Work commitments often preempted time Singh planned to spend with his family. He said, "Lots of time we planned to go away for the week-end, and Friday came and I won't come home." His work commitments kept him at a distance from his children.

Within the family Hamilton seemed to be on the periphery. He was more like an appendage. "The father is from the beginning someone who is just there, this does not mean that he is there for nothing, but that he is not there for anything" (Langeveld, 1971, p. 211). Hamilton's major function seemed to be providing for the material things in life. He "looked after them" but little else.

Singh's heart attack shook his complacency about his relationship with his family, especially with his children, and caused him to reappraise the ties that he now realized could be severed abruptly and permanently. Imagining a future for his children without him was disturbing. As Singh said, "I looked at my two kids and I couldn't think of them without a dad." He discovered their vulnerability and this seemed to underscore his desire to maintain some semblance of

control in the work place which he felt was, in part, responsible for his predicament.

Gradually the demands that were made on the post-MI patient before his heart attack may begin to surface again. He feels the pressure, which he is more aware of now than he was before. To escape the increasing demands of the work place he may, as Singh did, seek out a less demanding job which usually means a demotion. This is preferred to increasing his risk of re-infarction. Finding another position, however, may be difficult because of a prejudice in hiring post-MI patients--especially in the semi-skilled and unskilled sectors of the labour force, where physical stamina is a prerequisite.

His heart attack seems to change the way he thinks and feels about work. Once work appeared to be the pivotal point in his life; he organized his life around work. After his heart attack, he is less achievement oriented; this is seen in his determination to place limits on what he will do if he is in a position to do so or to enlist the help of others in his fight to maintain control over his life. He confines himself to what in his view, is important. He is less task-oriented and more people-centred. He discovers or re-discovers his family and he makes time for them.

Experiential characteristic three: The post-MI patient may no longer be prepared to let his work commitments stand in the way of being with his family.

Along with his affliction came feelings of the enhanced significance of others, and he is reoriented toward the meaning of his relationship with his family.

The Other Creates Distance--Being Seen as an "It"

The other person often enlarges the distance between the post-MI patient and his world by acting as though he cannot do anything for himself or by unintentionally drawing attention to his shortcomings in a number of ways. The ground for this distancing is predicated on "the look," since we present ourselves to others through our bodily being. Thus, if the post-MI patient feels that his body is being objectified by the look and treatment of the other--who may rush in and take over--his relationship to the other undergoes a process of objectification as well. Consequently, the other has the potential for modifying the post-MI patient's being and his world.

The Look as an Obstacle to Engaging his World

In the CCU it is impossible to escape the look: the MI patient is continually under observation from which he cannot flee. He is virtually immobilized by the intravenous needle inserted into his arm and by the electrodes leading from the cardiac monitor to his chest wall. The functioning of the heart is under constant surveillance, and consequently his every move is subjected to scrutiny. Woytowich recalled:

It was a very funny sensation when you lay there and you were

> not supposed to move your arms and not supposed to move your legs and you were not supposed to do anything. And the nurse stands by you to make sure you don't.

Singh said:

> They could see you all the time; the Nurses' Station was right before your eyes.

Likewise, many of the bodily functions, such as having a bowel movement, becomes a "public" event. It was an event which Lesher (1978) wished to avoid, even at the risk of having another heart attack:

> I rejected the mild laxatives the hospital offered me despite the apparently sound reason that even the strain of constipation might trigger another heart attack. But the thought of sitting on an enlarged potty chair, surrounded by my ever present wires, and worrying that a nurse might interrupt me to take my pulse or temperature precluded any interest I might have had in a successful bowel movement. (p. 53)

The watchfulness of the health care professionals is replaced by that of the family, especially his spouse, when the post-MI patient returns home. His wife "keeps an eye" on him. At first it seems that nothing escapes her look. They are in such close proximity, what else can he expect? Moreover, his wife feels she must watch over him and keep him from harming himself by overexertion and strain (Croog and Levine, 1976). Her surveillance is frequently continuous and unrelenting. He, intent upon engaging in some tasks, sets out to do just that; she, at least momentarily, stops him in his path: "I will do that for you," or at least intimates that what he intends to do is beyond his capacity. His wife becomes an obstacle to his project and distances him from the task. He is alienated from his possibilities (Sartre, 1966). By the mere appearance of the other he becomes an object of evaluation and judgement (Sartre). His wife focuses on his deficits; she lifts them out of the background and displays them at the very

moment when he is on the verge of becoming absorbed in the task at hand. Now his attention shifts from the project to an awareness of himself. If he persists in the task, it does not engage him fully. He is poised somewhere between the task and an awareness of himself; the other's intervention effectively precludes his full engagement in a presently intended venture and creates a "gnawing fundamental insecurity about himself" (Shapiro, 1985, p. 173). He cannot lose himself in the task and become the project.

The other, however, may create ambivalence. The task simultaneously attracts and repels him. "There are two distinct invitations implicit here, to move towards and to move away" (Shapiro, 1985, p. 187). Should he follow his initial inclination or should he abandon it? He is caught "being between" (Shapiro, p. 202). That created tension for Martin:

> You don't know what you can do, and you think you should try. I mean I was really quite scared when I first started [jogging] because I didn't know what would happen. . . . I can remember sensing that my wife really worried quite a bit about my taking up jogging, though she never said so. Indeed, what she did was to immediately get into it herself. . . . I was ambivalent too . . . and that kind of ambivalence [his wife's] reinforces ambivalence [his].

Martin confronted the situation and took the risk, but was he able to bridge the gap between himself and the task once it was enlarged by his wife? Did he abandon himself to his project?

Ambivalence has the potential for immobilizing the post-MI patient. He becomes stuck and loses access to "either possibility or development of possibilities" (Shapiro, p. 206). The other seems to disengage the post-MI patient from his project, and he loses an oppor-

tunity to move beyond his present situation. Moreover ambivalence has the potential for "creating conflict over doing and not doing something" (Shapiro, p. 174). Hence ambivalence could give way to conflict.

Experiential characteristic four: Constant surveillance diminishes the post-MI patient as a person. It may wrest control from him.

The Look Distances the Self from the Other

The post-MI patient is constantly being watched over and smothered with concern. With the other's look, the situation escapes him; he is "no longer master of the situation" (Sartre, 1966, p. 355), as Singh's situation demonstrates:

> If I go out to cut the lawn, if I start digging the garden, or spading the garden, she [his wife] won't let me do the whole thing in one day. She says, "I think you have done enough."

The husband is now guided by his wife; her interventions are aimed at protecting him (Croog and Levine, 1976). Shaw said, "My wife bawls me out for that [going to the office early and leaving late]." And Hamilton's wife tells him, "Don't do this, don't do that . . . watch what you eat." The nature of the relationship changes when the wife takes on a managing role--"don't work so hard," "don't overeat"--and this has the potential for driving a wedge between them. Even years later the post-MI patient may revolt, deciding that he is so "fed up

with the necessary restraints on him that he will ignore them and take his chances" (Schoenberg and Stichman, 1974, p. 225).

In addition, this overprotective stance may prolong feelings of impotence and generate feelings of resentment. As the post-MI patient's wife blocks his attempts to engage his world, she may inadvertently convince him that he is an invalid; and as he becomes more dependent, he becomes more demanding and irritable, and the atmosphere is filled with tension and hostility and this could drive them apart.

There is an alternate path to invalidism: that is the path that leads back to the world. But in order to become firmly established on the latter path, he must persists in doing what he wants to do and is capable of doing in spite of frequent admonitions to the contrary.

Experiential characteristic five: Care in the period immediately following the heart attack may be experienced as control, as time goes on, when the post-MI patient's attempts to change the status quo are met with resistance.

The surveillance does not seem to abate, but as time passes it is more subtle. When the post-MI patient returns to work, he escapes his wife's gaze, and there is a respite from the continuous surveillance of the convalescent period. As Radowski related: "It was a change to go back [to work]. You sort of feel when I did go back, I thought I could do things on my own without anybody watching me."

The demands of the work place, in their own unique way, have the possibility for creating distance between the post-MI patient and the other. In Mulder's situation he has more flexibility in determining when he will be present. He is usually in his office by 10:00 a.m. Although, he said, "There is a lot of pressure on me to go early for a meeting at 8:30 a.m. I say I can't come before 9:30 a.m., mostly at 10:00 a.m. But if there is a meeting, the earliest I go is at 9:30 a.m." He adheres to his routine so as to get adequate amounts of sleep, he sleeps until 8:00 a.m. By resisting these demands he draws attention to himself. What kind of difficulties does this failure to comply with his colleagues' requests present? He cannot avoid them (colleagues). Does this create tension in the work place?

Mulder has control in his work situation which is not physically demanding. What happens to persons where the work is physically demanding? They cannot disregard, for example, chest pain or chest discomfort when it is brought on by physical demands. They must seek assistance from fellow workers. Depending upon the frequency of the requests, this could generate resentment from their colleagues and feelings of impotence for the heart attack victim. Hence, the other's demands not only distance him from his fellow workers, but also distance him from himself. He abhors being dependent. The other's demands force him to evaluate his situation and to make a decision as to whether or not he is able to carry out the project unaided. He is placed in a position to pass judgement on himself; and when he finds himself lacking, it is distressing.

Responses to the "Look"

It is easy to draw attention to oneself whenever you are out of sync with the hustle and bustle of the everyday lifeworld, whether it is in the work place, climbing a flight of stairs, or walking along a busy street. When the post-MI patient experiences chest pain, he must stop whatever he is doing and take his medication. This draws attention to the individual. People may stop to ask if he requires assistance, or they may just look.

Experiential characteristic six: When the post-MI patient's body fails him, then the social consequences can be increased subjectivity [care] or increased objectification [stare].

The individual becomes an object to be stared at. His body becomes an object for the other, and the other's look makes him aware of himself as an object. "If someone looks at me, I am conscious of <u>being</u> an object" (Sartre, 1956, p. 363). The body has lost its vitality; it has failed him. The body becomes a source of embarrassment. He cannot maintain the "pace," and he becomes an object to be stared at.

Being stared at can be disturbing. The context in which the look occurs is an important factor in how the person being stared at will make sense of it (Stack and Plant, 1982). In the work place the individual may be distanced from his fellow workers. He is not one of

them; he is not doing what they are doing. They look at him and pass judgement. How can he relate to them? There is a gap that separates them.

Being stared at may elicit embarrassment. For some time after his heart attack, Singh felt embarrassed when he went grocery shopping with his wife because he could not assist her with lifting the heavy bags. He said, "Everybody would look at me, and look at her. So I wouldn't go to the grocery store with her." If Singh did accompany his wife, to spare himself the embarrassment of being looked at he made his exit when she was at the check-out counter. Normally, the post-MI patient makes a completely healthy impression until he finds himself in a position which tests his limits and which may reveal his shortcomings. If he wishes to forestall this display, he must avoid the situation. To consider such a "strategy" as Burch[7] pointed out "is still to admit the shortcomings to oneself--perhaps worse, to develop a 'hide' mentality."

The desire to conceal his shortcomings may place limits on being with old friends. Before his heart attack, Radowski enjoyed socializing with his co-workers. When they went to the bar he drank as much as he wanted to. Now it is different; he has only one or two drinks and this makes him feel "as though you are sort of getting left out in a way." Radowski feels pressured to do what his friends are doing, but he knows he cannot. He said, "You just look at it and you think to yourself, I wouldn't mind doing it, but [he paused] it kind of puts you

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[7]R. Burch (personal communication, August 20, 1986)

down you can't do it."

There is this push/pull feeling. He is pushed in one direction at the same time that he is pulled in another. He wishes to be with his friends, but being with them only accentuates his differences--differences that he would prefer to downplay than to highlight.

Experiential characteristic seven: The post-MI patient may regard his physical limitations as "differences" which separate him from others.

An invitation is an act which occasions a coming together of people of like minds and similar interests. Implicit in this coming together, in a social context, is that those who gather are in some ways compatible and are expected to engage in the main objective of the gathering. It provides an opportunity for people to interact, to enjoy themselves, to be themselves. It is like time-out, a brief respite from the cares of everyday life; it is a chance to recharge.

Since the invitation is based on the assumption that those who gather share a common interest and modes of behaving, anyone who deviates from the expectation becomes the focus of attention. The group's energies are channelled in his direction, and he feels the pressure to conform. Hence to accept an invitation "to have a few beers" with fellow workers at the end of the working day is to consent to participate. If he does not, he risks the chance of drawing attention to himself. Ergo, to decline the invitation is a way to avoid

this. In declining the invitation, however, the individual momentarily draws attention to himself and his differences. The invitation becomes the occasion for revealing the difference between them, and this difference creates a sense of distance--a social space.

Is Radowski's delay in seeking employment a means to avoid being scrutinized and rejected by the other? And what if he were successful in finding another job and he were asked to do "something and you can't do it because it is hard on you. What are you going to say?" Once again the distance surfaces, not of his own volition but rooted in the demands of the other.

Experiential characteristic eight: The post-MI patient's personal sense of difference may mean difficulty in his experiencing sameness, or oneness with his fellow beings.

While the reactions to the look vary, they reveal the discomfort which the look generates and the attempts of the post-MI patient to escape the scrutiny of the other. When his chest pain necessitated standing still in a public place, Mulder learned to cope by pretending. He would pretend that he was looking at something which caught his attention. The other's curiosity provoked embarrassment and he reacted by pretending. Singh learned to cope with the embarrassment of being stared at when shopping with his wife by leaving her at the check-out counter while he escaped to the mall. In other words, he avoided a

situation which made him conspicuous.

Does the post-MI patient cope effectively with the situation by avoidance and by pretending? Webster's Dictionary defines coping as "dealing successfully with a situation." To cope effectively with the situation where the other's look creates distance would be to close the gap, to eliminate the distance. In avoidance, he physically removes himself from the situation which makes him conspicuous to avoid attracting attention to himself. But this action means that he cannot be where he wishes to be: he is being controlled by external forces which maintain the distance between himself and the situation. In pretending he "makes a false appearance" (Webster's Dictionary), for he strains to sustain an appearance which is not rooted in his being. For Mulder, his forces are scattered; he cannot be his pain. He has to be something else, so he hides behind a false appearance. The distance surfaces. Does the post-MI patient deal successfully with the situation by pretending and by avoidance? How does avoidance and pretending facilitate his capacity to be an authentic human being?

The passage of time affects the post-MI patient's situation in at least three ways. First, he may choose to let that part of him that wishes to challenge his limitations surface. Hence, he dares to ignore the risk and he takes his chances. He will do, or at least attempt to do, what he wants to do. He gets up and he gets going. He no longer permits the other to disengage him from his world. If the other persists, then the distancing shifts from the tasks to the other. Now the distance is between himself and the other, who finds it hard to let go. Second, in the work place and in social situations, the other may

forget that he has had a heart attack. This, however, has its disadvantages since the other's expectations may exceed his capacity. He is now distanced from the other and from the task; the task being any purpose for the coming together.

Third, the post-MI patient may engage in information management in an attempt to conceal his shortcomings or to reduce the chances of being given special treatment which is unwarranted. In addition, he may control his association patterns--which set him apart--so as to avoid being identified with a particular group. Yet during the convalescent period he may be willing to associate with persons who have had a heart attack by participating in a cardiac rehabilitation programme. Furthermore, he may continue to exercise with the group but decline opportunities to participate in the social life of the group.

In short, the post-MI patient's interpersonal relations are fraught with instances which distance him from his world and in some cases from himself. This may force him to adopt a position which is contrary to being himself. He may resort to pretense and avoidance as he searches for ways to conceal his shortcomings from the other.

CHAPTER 7

TEMPORALITY: TIME IS LIVED IN EVENTS

Introduction

For Shaw and Woytowich, survival is important. Shaw wants to live. Woytowich, too, said, "Survival is the thing." But it is not existing for the sake of existing; both want to enjoy life. They do not wish to survive as cardiac cripples. That would be no way to live. They must make changes, since as Woytowich recalled, "the heart attack changes you. You are a different person." Survival and being able to enjoy life means you have to make changes in the way you live. Thus, the heart attack becomes the occasion for taking stock.

Due to technology, they both know the conditions of their coronary arteries, and this determines how much they can realistically expect to do. Before his heart attack, Shaw had maintained a "hectic" life style. He attended all kinds of functions, sat on "a whole bunch of boards," and was constantly on the go. He smoked and enjoyed a couple of alcoholic drinks each day. Woytowich had worked full-time for a collection agency and he was constantly engaged in confrontations with his clients. He, too, smoked.

In taking stock, they both realized they enjoyed life and they

wished to continue to do so. But surviving would mean change. They could not maintain the pace of their past lives. However, the past lives on in the present, since their past to a large extent dictates what is done in the present. In the present they live in such a way as to remedy the ills of the past. Reducing their risk factors means abstaining from or modifying past behaviours. For example, both have quit smoking and work shorter hours. Moreover, there is another way in which the past lives on in the present. This is seen in the many ways in which events and people remind them of their heart attacks. Woytowich feels that people overextend themselves to make life easier for him "because you have had a heart attack." Shaw's wife reminds him to take his medication and "bawls" him out when he works long hours.

They are both living with an awareness of what comes first. There has been a reordering of priorities so that they are able to survive and to enjoy life. In the business world Shaw attends to what he considers to be important and leaves the details to others. In addition, he takes time off to enjoy life. Woytowich is no longer prepared to jeopardize his health for his work. When the situation becomes tense, he can say "to hell with it" and walk away from it. Before, he said, "I wouldn't think of doing that. I would stay with it until it finished one way or the other." Now, they live with an awareness of what they want from life.

Taking Stock

At first, the diagnosis of heart attack may be greeted with disbe-

lief. "It's impossible. He must be wrong," said Woytowich. It was two to three days later that Woytowich convinced himself that he had indeed sustained a heart attack. A heart attack represents a break in the continuity of the individual's experience. He is "suddenly and unexpectedly thrust into a strange world in which his life is in some danger" (Abbott, 1979, p. 191). There is an abrupt transition. The question "Why me?" may surface. In asking the question, there is a return to the past, since there is generally an awareness of the preceding events. The past lives in memory and is accessible by reflection. Reflection, as Marcel (1950) notes:

> occurs when, life coming up against a certain obstacle, or again being checked by a certain break in continuity of experience, it becomes necessary to pass from one level to another, and to recover on this higher plane the unity which had been lost in the lower one.(p. x)

Hence, by reflection the past is brought into the present. The past becomes significant in the present. "Before the heart attack," Hamilton said, "you don't think. When it happens to you, you start thinking about what you were doing and where you went wrong." He recalled, "I didn't eat properly, didn't get enough rest and it was go, go all the time. . . . I had to be the first in in the morning and the last one out at night." "Why me?" became an appeal to enquire into his life. What has happened "receives its significance and value from its temporal position in the individual's life history" (Wessman and Gorman, 1977, p. 43). The present is experienced as meaningfully connected with the past.

When the question "Why me?" is asked, the post-MI patient interrogates himself about his lifestyle. Shaw rarely took a vacation.

Mulder drank about twenty cups of coffee each day, smoked forty to fifty cigarettes, and worked long hours; but he said he "enjoyed" his work. He liked being active and "the prospect of a quiet life" was not attractive to him. He too rarely took a vacation. Singh had worked hard (and still does), but now he is not on call twenty-four hours each day, seven days a week. After his heart attack he also searched for a cause. His search led him to the literature and there he discovered a link between the tensions of high-pressure jobs and heart attacks. This helped him to make sense of his situation. He said he was not able to sleep at night because he was so tense. In recalling the past we usually contrast it "with the present and thereby gain a new perspective on the past" (Wessman and Gorman, 1977, p. 42). The past can be reconstructed in the present so as to make sense of it and to give meaning to the present.

Experiential characteristic one: The post-MI patient recollects events of the past in order to make sense of the present.

Taking stock, therefore, not only serves to find causal relationships but it also serves to make sense of the event. One's beliefs, in a large measure, determine how one makes sense of a situation. It is more difficult to make sense of it if one feels, like Radowski, that he had "good health habits before"? He had maintained his ideal weight. He felt that he received adequate amounts of sleep and rest and that

his work situation provided him with all the physical activity that he needed. In other words, his work was physically demanding and he put his body through its paces each day. Admittedly, he had smoked for fifteen or so years. He found the cause in the environmental conditions--the dust-filled environment in which he worked--not in his health care practices.

One's beliefs may be one way of making sense of a situation. But is there another way of looking at causality and consequently how one makes sense of a situation? Is it possible that one's sense of causality may be related to one's notion of time and consequently to how one makes sense of a situation? Cottle (1977) suggests that there are two perceptions of time--the Gestalt and the atomistic. In the latter, "the time zones are distinct . . . they are separated from each other" (p. 175). In the former, "the present passes continuously into the future as the past flowed continuously into the present" (p. 175). Apparently, we hold both notions of time simultaneously. Cottle continues:

> If this is true, then one's sense of causality, which develops in great measure from conceptions of time, is affected by these fundamental styles of thought: persons who tend to see parts within a particular whole as being disconnected should be less capable of perceiving relationships between parts. The Gestaltist perceiver, therefore, should see not only relationships between time zones but ways in which one time zone affects events in other time zones. (p. 175)

Hence the Gestaltist perceiver may be more capable of reconstructing the past to normalize his heart attack. That is, the Gestaltist perceiver is able to make sense out of the heart attack by relating his past to the present. But the atomistic perceiver is not able to make

the connection because he cannot see the relationship of the parts to the whole, the past to the present. He fails, as Cowie (1976) and Levy (1981) found in their studies of MI patients, to successfully reconstruct their pasts.

Experiential characteristic two: The post-MI patient's perception of time may be an impediment to his ability to construct a new reality or vice versa.

Taking stock, for the participants in my study, began in the hospital. For the first time, the post-MI patient may become aware of the things he enjoys doing and what is important to him in life. The heart attack was seen as an obstacle to those activities which Woytowich enjoyed with his children, since those activities were physical in nature and demanded stamina and endurance. He feared his heart attack would change this. Singh and Martin had young children and they engaged in many physical activities with them. These activities were taken-for-granted, they were not primarily significant at the time they took place. Van den Berg (1974) eloquently speaks this truth: "The past is not primarily significant at the time it was taking place. . . . The past is significant now. . . . The past that is significant is a present past" (p. 80). Furthermore, "the past cannot be recaptured except in fragments" (Marcel, 1950, p. 155), and these fragments are lifted out and examined in detail. The whole is lost in the

process, thus the events take on a different dimension. Recalling the past, then, is like looking through a pair of binoculars where certain elements are enlarged and others fade into the background. The events are isolated from their content and deprived of their meaning (van den Berg, 1970, p. 15). However, recalling the past is the basis for perceiving time and for anticipating the future.

One's whole being comes into question when one takes stock. Martin's situation is a case in point:

> I don't know if I seriously questioned before the heart attack what the hell I was about. I was going hard at it. Maybe that is the bottom line of the whole thing that it does throw a very large question mark into your whole mind set, your whole life.

The negativity of the experience opened his eyes. Moreover, the post-MI patient will never be able to take good health or even living for granted anymore. His heart attack changes that. When confronted with a crisis it is, as Marcel (1950) says, "as if the ground were crumbling under his feet" (p. 153). However, little by little the pieces begin to emerge. Hamilton discovered that he is a very aggressive person, Woytowich used to see things through to the bitter end no matter what, and Shaw wasted very little time. In order to save time on business trips, he travelled at night, worked all day, and made his return trip at night. What emerges in taking stock are fragments out of the past. As Marcel (1950) points out, in recalling the past:

> we are given certain luminous fragments out of the past, the mind . . . has to work hard to rebuild the rest of the past around them . . . rebuilding of the past is really a new building . . . modelled more or less on the former edifice . . . but not identical with it. (p. 156)

Experiential characteristic three: The past as recollected is not the past that was lived through. Yet it is truly the past so recollected that is significant in the interpretation and experience of the present.

In getting in touch with himself, the post-MI patient is able to respond to others, and he is capable of empathizing with other people or even imagining their situations. As Mulder stated: "I tried to walk slowly in the beginning. I really felt old, because I could not walk normally... I realize how bad traffic lights are to older people. Because it changes and you have to hurry up." Martin discovered the emotional aspect of his being and is able to empathize with women who can let this aspect of their being surface. Both Mulder and Martin were able to break through the shell that encased them and to be open to others' experiences.

There is a motive, however, for taking stock, for asking "Why me?" As van den Berg (1974) notes, "to understand something one has to comprehend its origins" (p. 86). The post-MI patient can only apprehend the event by returning to the past; the present cannot be understood from the present since "events fit into the continuous narrative of our life histories" (Wessman and Gorman, 1977, p. 40). Furthermore, our experience of time lies in events so we must return to the events if we wish to comprehend the present situation.

The Past Lives in the Present

A heart attack is a life-threatening situation, and it may be the first time that the individual is confronted with his mortality, as all of the participants in my study implied or stated explicitly. The post-MI patient becomes aware of his finitude and that there is a limited amount of time available to him in which to realize his projects. In taking stock, the post-MI patient realizes that he could have done things differently, and consequently that he can do things differently. In fact if he wishes to survive he may have to make changes, and these changes are rooted in the past.

Shaw has changed his attitude toward work and his work habits. As he said, "If you hadn't made it, somebody would have been doing it anyway, so you might as well make up your mind that other people know how to do things and can be responsible for things. So you gradually let go." Woytowich, too, realized that he was not indispensable. "It's quite a feeling to know that you are going to be left aside and the world can carry on without you." There is only a finite amount of time for everyone (Cousins, 1983), and both Shaw and Woytowich are living this awareness. The locus of time is in the dynamic interplay between the individual and his environment. As Merleau-Ponty (1945/1981) points out: "Time is, therefore, not a real process, not an actual succession that I am content to record. It arises from my relation to things" (p. 412).

In taking stock, the post-MI patient is confronted by aspects of

his lifestyle which may have contributed to his heart attack. He avoids doing things in the present which created problems in the past, therefore, he may attempt to change his risk profile. What does this involve? Is he prepared to make the sacrifices? He wants to enjoy life, for mere living is not enough. Is there another way of living that would facilitate his goal? All the participants in my study made changes. Those who smoked gave it up, and some have been able to maintain their ideal weight. Shaw adheres quite rigidly to the medical prescription. He may have sustained a second heart attack--this event coincided with his lapse in following the medical regimen. He had returned to his old work habits, and he feared that a "third strike" might be "game over." This seems congruent with his fatalistic attitude in the first place when he said of his first heart attack, "If it happens, it happens." Now he seems less prepared to tempt fate and is being guided by the past, "the past," which van den Berg (1974) says, "provides the conditions for what is going to happen in life" (p. 86).

Experiential characteristic four: The post-MI patient's living in the present involves doing things differently so as to remedy the errors of the past.

Shaw, then, has made a concerted effort to do things differently. On the one hand, dwelling on the past may exact a price as the individual may become estranged from his authentic possibilities. On the

other hand, being aware of the past, the challenge of living in the present is whether he would revert to his old ways of doing. For both Shaw and Woytowich, surviving and being able to enjoy some more of life is important to them. Hence they must live in such a way that they are not estranged from their possibilities. This can be said for the other participants as well. They all wanted to maximize their potential for living life fully. Their interest extended beyond the proper functioning of their bodies. They wanted to live life more intensely. Martin feels he is a more integrated person, and his interests have diversified. He has made a determined effort over several years to change his lifestyle.

The individual's sense of invulnerability was shattered by the heart attack, so he is left with a much greater sense of wariness. "I think the person looks after himself much better after," said Radowski. "I think he has to. He really doesn't have much choice. If you don't, it's going to be another one or whatever." It seems as though he is now "forcibly aware of how precarious a seeming state of well-being can actually be" (Mullen, 1975, p. 187). This heightened awareness of the post-MI patient's sense of his mortality forces him to take stock and to be mindful about what he does. Hamilton, who never exercised before his heart attack, now exercises regularly. So does Radowski. Woytowich smoked for years; now he no longer does, although he was determined that he was not going to quit when the doctor counselled against continuing. Shaw believes that if he had not had a heart attack, he would have continued to smoke. Hamilton "tries to get as much rest" as he can. Admittedly, this is difficult at times because

he likes being active. He has always been active.

Maintaining one's ideal weight can be a problem. It involves working at it, as Hamilton discovered. It also involves making sacrifices, and it has the potential for drawing attention to the individual in a social situation. Whenever Hamilton is obligated to attend a business lunch--he has a salad, in the past he would have "a big steak and all that stuff." He also had "a big gut," which has now disappeared. So within the temporal structure, the individual apprehends both a daily agenda (the present) and an historical perspective (the past). The present, however, "usually contains some anticipation, however vague and uncertain, of what is to come" (Wessman and Gorman, 1977, p. 39). This for the post-MI patient is the lingering presence of having had a heart attack which may recur.

All of the participants reported that at some time or other when they were about to engage in some form of strenuous activity for the first time, they would stop and assess the situation. For example, sometimes when Martin is about to lift "something <u>really</u> heavy" he has wondered "on the odd occasion" whether or not he should be engaging in that kind of activity. Thus, it has occurred to him that he could be placing himself at risk. His hesitancy has to be understood in terms of the experience from which it emerges.

Another way in which the past lives in the present is that there is always, or so it seems, something or someone to remind the post-MI patient of the event. Attending a cardiac rehabilitation programme is a constant reminder. There the individual exercises with other post-MI patients. The very exercise routine is a reminder. In the exercise

class they often do things differently. They are constantly reminded to check their pulse rate, to slow the tempo if they exceed their target heart rate, and usually there is a personal file in which the participants record their pulse rate. This file is also used by the staff to communicate words of encouragement or reprimands! For example, "You exceeded your target heart rate, slow down." In addition, Shaw related that they shower together after the class and people talk "quite freely about their problems." Attending the exercise class extends the post-MI patient's experience. It gives him a new reason for carrying on, or as Marcel (1950) would say, "a new foundation to build life on and this is something difficult to do and often very painful to do" (p. 164).

For Mulder and Radowski, having a medical check-up is a reminder. What will the doctor find? Radowski finds waiting in the doctor's office the most stressful, but once he begins the stress test he knows all is well. He can tell. What the doctor has to report a week later is not unexpected. What if he did not trust his intuition? Waiting a week to get a definitive statement could seem like an eternity. In the meantime while he waits he can continue living. His plans are tied to his capacity and how he sees his situation (van den Berg, 1966). By forcing himself from the constraints of his immediate situation, he accepts responsibility for himself.

Applying for an insurance policy, as Martin did recently, served as a reminder. He would have to pay a "ridiculous premium" because he had a heart attack, even though it was twelve years before. He is stigmatized by his heart attack; he is now a marked man. He cannot

forget his past. This aspect of his past will stay with him forever.

It seems as though the spouse of the post-MI patient never forgets. While Shaw's wife is more direct in her approach, she "bawls" him out for going to the office early and leaving late and chides him for behaviours which she feels are inappropriate. Woytowich's wife is less direct in her approach. She is more inclined to phrase her admonitions in terms of what she is going to do: "I am going to put you on a stricter diet." She may admonish in terms of what he should do: "You got to exercise more."

The post-MI patient is also reminded of his heart attack when others do for him what he feels capable of doing. In the winter time, Singh's son shovels the snow in the driveway before his father returns from work. This is done deliberately. Radowski's friends, who go fishing with him, took a cardiopulmonary resuscitation course. While this gives him a sense of security, it is nevertheless a reminder of a past event which could recur in the present. Each of the participants in the study admitted that the memory of the event lingers on. It is always "in the back" of their minds. So forgetting is never total, although they may not think of it for several months. But it may be five to six years after the event before these "memory lapses" occur, and it only happened to those who were not involved in a regular cardiac rehabilitation exercise programme--Mulder and Martin. Although Singh may go for "weeks on end" without thinking about his heart attack, he always remembers his anniversary. It is not a happy event, it is depressing. Why? Does that date signify an end of a way of life and not the beginning of another life?

Experiential characteristic five: For the post-MI patient, forgetting the event is never total--the memory is now a silent partner.

Living With the Awareness of What Comes First

Living with the awareness of what comes first means that the post-MI patient consciously selects certain situations over others, that he is aware of his options which are in accordance with a re-thinking of his goals, and that he responsibly owns and enacts certain commitments. First and foremost there is the will to live, not just to exist, and this to a large extent determines how he will live. As Marcel (1950) suggests, one's life "is articulated on a reality which gives it a meaning and a trend, and as it were justifies it" (p. xiii).

Shaw discovered a different way to be involved in his work situation. He was willing to delegate more and to concentrate his energies into what he finds interesting and challenging. For Woytowich, working full-time was too stressful; instead he returned to work part-time. This permitted him to remain involved but at the same time to reduce the stress level which is an integral part of his work situation. Moreover he, like Shaw, derives much satisfaction from his work situation which is part ego and part habit. Shaw and Woytowich see their jobs as challenging. Both remain involved, but the time after their heart attacks is characterized by a time of its own since a change in

plan effects a change in time (van den Berg, 1970).

Experiential characteristic six: The experience of a heart attack may profoundly affect one's sense of life's priorities.

Martin's heart attack became the occasion for taking the time to reassess his life, to identify what was important to him. As Marcel (1950) shows, to speak of life is to ask one's self "what point it has" and maybe "even whether it points in any direction at all" (p. 172). Martin discovered that in living through and living with a history of a heart attack, "life becomes more a metaphor. It is what you make it." It is living this awareness. In other words, it is assuming responsibility for his being. In part this entails compliance to the medical regimen, but this does not mean blindly following instructions.

The medical regimen is an invitation for the post-MI patient to confront himself: to discover who he is, what he realizes and fails to realize, and how he comports himself. He is moved to evaluate himself. Woytowich is "very conscious" of what he can do and what he "is not supposed to do." He said:

> three or four years ago I wouldn't have thought about grabbing the shovel and moving the snow because it had to be done. . . . Now I grab the shovel and maybe I will throw a couple of shovels full, and lean on the shovel which I would never have done before.

On the one hand, Woytowich lives a second chance so he is more cautious in some respects, but on the other hand he is more in tune with himself and with what is important to him. His future is connected to his wish to live and is to a lesser extent related to other

people (van den Berg, 1974).

The post-MI patient seems to have a heightened awareness of what matters most. This means he is sufficiently self-aware to recognize his limitations and capabilities and that he constructively finds ways to meet his goals. Singh works at being a father. Shaw now takes more vacation time and plays golf often, even if it means taking time off from work to do so. Mulder has learned to say "No" to unreasonable demands on his time. It seems that living through a heart attack has left each of the participants, in my study, with a fuller sense of life as they discover other dimensions of living. There is an inward turning, and in so doing the post-MI patient discovers more about himself than he ever knew before. This revelation gives direction to how he lives. He becomes less tolerant of trivialities.

Experiential characteristic seven: The post-MI patient's encounter with death may give him a heightened awareness of time and change his outlook on life.

The encounter with death paradoxically seems to open up, for the post-MI patient, options for living life more fully. He may discover, as most of the participants did, that his life centred around work--work which, in retrospect, he believed contributed to his heart attack. But whether or not this was so, he realized that he would have to change his work habits if he wished to survive. This has practical consequences. He would have more time for himself, to create, recognize and exercise options.

CHAPTER 8

SPATIALITY: CREATING A WORLD FOR ONESELF

Introduction

Before their heart attacks, Martin and Hamilton spent most of their waking hours engaged in work-related activities. In the work place, however, they were in command of the situation. They each had their own staff who carried out their orders. They were, to a large extent, in control. Then, suddenly, sustaining a heart attack, this changed within a matter of hours. They were admitted to a CCU where they found themselves caught up in a situation which, on the one hand, they could not ignore, and on the other, they could not control. They were now at the mercy of the health care professionals who decided what information they should have access to and what they should do and when.

Each place has its own mood and atmosphere, and this is coupled with certain expectations. Hence this determines the individual's expectations of that space. Places have meaning, and the individual responds accordingly. Martin's immediate reaction was to update his will. Hamilton experienced a recurrence of chest pain and he was afraid that he would not survive. His stay in the CCU was short-lived, however; as soon as he was seen by his cardiologist, he was tranferred

to the step-down unit, a move which gave him reason to be optimistic. Martin too, in the normal course of events, was transferred out of the CCU. Martin had mixed feelings about the move: from one perspective it represented progress, from another he wondered if the doctors really knew what they were doing because they were unable to explain the occurrence of his heart attack given that he was twenty-eight years old. Were the doctors being hasty in their decision to transfer him to the ward?

With each change in locale, there was a graduated increase in physical activity, so a change in place was accompanied by a change in pace. Martin and Hamilton went from being virtually immobilized in the CCU to being able to walk in the hallways of their respective wards before they were discharged home.

Both Martin and Hamilton were anxious to return home. In the hospital, Martin resumed some of his work-related activities; but he felt it would be more convenient to work from his study at home than from his hospital bed. He insisted on going home at least one to two days earlier than the doctors had recommended. He was subsequently re-admitted for observation, a day or two later, when he suffered chest pain.

Martin and Hamilton were soon bored being at home. They were unaccustomed to spending much time there. They wanted to return to their work place, so within a month of discharge from the hospital they had returned to work. At first, Hamilton reduced his working hours because he was too tired to work full-time. Initially, Martin found that if he pushed his limits and tried to do what he had done before,

he experienced cardiac symptoms. This left him in a quandary. How far should he go? His appeals to his cardiologist were to no avail. He alone would have to decide what he could do.

Although returning home and later to the work place was returning to a familiar landscape, initially both men experienced difficulties. Being ill means "first and foremost that the surroundings have changed" (van den Berg, 1974, p. 45). The atmosphere was coloured by their physical capacity to act. Both, however, were able to re-structure their involvement in their work place so as to create new possibilities. Within two to three years of his heart attack, Martin gave up the courtroom for the classroom. Instead of being engaged in the practice of law, he became a professor of law. Now he spends more time doing research than teaching. Hamilton, who owns his company, was able to distance himself from trivial concerns and stress-producing situations by delegating responsibilities to others. In other words, he is "protected" by others; they shelter him from the daily irritants of the work place.

Martin and Hamilton are both doing what they want to do, in the work place or elsewhere. Martin says that in the work place he is "marching" to his "own drum." Hamilton likes being active and he, too, says that he does what he wants to do and is enjoying it.

A Change in Place, a Change in Pace, a Change in Meaning

We are always involved in a place (Benswanger, 1979). Places have meaning. How does the MI patient experience that space through the

doors that open into the CCU? What does that space speak to? To Hamilton it had an ominous aura. Everything "looked dark" in the subdued lighting, and he saw "a lot of sick people." For him, that was "scary." Woytowich's experience was different--he took his cues from the nurses. He felt that the nurses treated him like an "ordinary patient" so he concluded that he was not "all that sick," because if he were, he would be given "special treatment." He said, "When a nurse comes around and babies you and everything else, you get the impression that they are looking out for you." That was not his experience. So Woytowich defined his situation in relation to how others treated him.

In the CCU there is a shrinkage of lived space, as the MI patient is confined to his bed and he is restricted in what he is allowed to do. For example, he is prohibited from pushing or pulling the over-bed table or reaching into his bedside locker. In addition, the electrodes which are attached to his chest wall are a constant reminder that his life is in some danger. Thus just being in the CCU heightens the MI patient's awareness of how tenuous life can be, and there may be a tendency to focus on death as a possibility rather than on survival and returning to a normal way of life.

On the one hand, being in the CCU gives the MI patient a feeling of security since he is under constant surveillance; should an emergency develop the team acts promptly. Singh could attest to this. One day he awoke at twelve noon to find himself surrounded by a team of doctors and nurses, his family, and his minister. It seemed as though he might have suffered a cardiac arrest and he was successfully resuscitated. While Hamilton's experience of the team's efficiency was not

personal, he did witness it when one of his roommates had a cardiac arrest. Furthermore, Martin was happy to be transferred out of the CCU as it was indicative of "some kind of progress," but he worried "deep down" because they still had not been able "to explain" the situation (recall he was twenty-eight years old). He feared that he was being prematurely transferred to the ward where the surveillance was not as intensive.

On the other hand, the hospital experience--especially in the CCU--may generate feelings of loss of control. Martin "felt safe" being in the CCU but being "doped up to the eyeballs" seemed like a loss of control. And for Martin, that created feelings of panic. He was used to being in control. In the work place he had set the pace, he gave the orders, his staff kept him informed. How else could he function with a three to four hundred case load? In the hospital he was at the mercy of others. Moreover, there were times when he had to make decisions, but he did not have all the information that he needed.

Cousins (1983) has something relevant to say about this loss of control in relation to stress testing, which some of the participants were subjected to. Cousins' doctor wanted him to take a treadmill exercise test, but he was "troubled" by this suggestion. He felt that the atmosphere in the treadmill room was tension-filled:

> The running blood-pressure readings; the mysterious markings on the cardiograph; the intensity in the voices of the cardiologist and the nurses--all these are emphatic and omnipresent reminders of a heart problem. (p. 55)

In addition, he knew of three episodes when serious problems occurred. He was "scared stiff" (p. 55). He, however, consented

reluctantly; but he was unable to suppress his "unreasonable fears," and the test had to be discontinued when he developed symptoms. He was persuaded to try again a few days later. This time he did not even step onto the treadmill: "Just the process of walking down the long hospital corridor to the treadmill room, all my foreboding came flooding to the surface" (p. 56). The test was cancelled. Six months later, he agreed to try again but this time he would create the milieu and control the treadmill. He began the test to the strains of Albert Schweitzer's recording of Bach's "Toccata and Fugue in D Minor" which he provided. Twelve minutes from the start of the test, against the doctor's wishes, he discontinued the procedure. He was "reluctant to press" his "outermost limits" (p. 99).

Experiential characteristic one: Feelings of loss of control in the hospital may negate the positive effects of feeling secure and create ambivalence for the MI patient.

Singh, however, did not experience his situation as a loss of control. Instead he was able to relinquish control. He saw the doctor as the expert, and he was willing to let him take charge. For example, he wished to spend Christmas at home with his family and was to a certain extent disappointed when he could not. But he resigned himself to the fact when each time the doctor came in and suggested he delay his return home. Singh said:

> I realized it was for my good. It was better for me to stay there. I could get home and the care wasn't there. I mean my wife is there, but she has no medical training. So I thought the longer they keep me there it is better for me.

Each change in place is indicative of progress. Moreover, each place determines what the MI patient can do in that setting. When he is transferred to the step-down unit and later to the ward, this usually means an increase in ambulatory time and the distance covered. It also means that the restrictions of the CCU are no longer in effect; hence he can interact with more people. In addition, he may be permitted a telephone. Visitors and the telephone enlarge his contact with the world yonder. Mulder, from the very beginning (he was not admitted to a CCU), wanted to have "some communication with the outside world," so he arranged to have a telephone installed. This gave him a certain amount of independence.

As the MI patient increases his physical activity his response is carefully monitored, so he is still being "watched" and there are restrictions. Like the child's experience of lived space in early childhood, which Benswanger (1979) studied, these spatial experiences unfold in a setting that others arrange and structure for him. As he began, however, to regain his strength, Mulder, like all the participants, started to get bored with the setting. He wanted to go home. Mulder did whatever he had to do to expedite the change in place:

> About two weeks before that, she [the doctor] said, "As soon as you can walk the stairs you can go home." So that day I started to exercise on the stairs. I could see my house, my apartment. So it was tempting. I was so glad to be back. And I pretended I could do it much more easier than it was true. I really had to stress myself to do it. I could not dress myself; I pretended I could do it easily.

Hamilton found his stay on the ward "very long." He was anxious

to return home. But he said, "I had to wait my time, I guess till the doctor told me. It was long days and long nights." For Woytowich, too, this was a waiting period, a time to be endured. "You can't do much about it," he said. "You just have to wait it out. It's pretty heavy on your mind." This time was even more burdensome when, as Woytowich discovered, he could not read "properly. Your mind doesn't seem to work properly all the time."

The day that all the participants eagerly waited for finally arrived, the day of returning home. None of them had been accustomed to spending very much time at home, so this was to be a new experience. At first they were amazed at how tired they felt. It meant they had to re-set their pace. Mulder recalled that he did everything very slowly and limited the amount of physical exertion:

> I stayed at home, I watched TV, slept, and looked out of the window. I had a nice couch in my living room and I sat a lot of the time. And if I felt weak I just lay down and that was it. I did that until March. So from January until mid-March I stayed home. But went out for a walk each day. . . . I always went as far as I could and then always tried to go a little farther.

Mulder's window became his window on the world--it enlarged his space; and each time he went a little farther on his daily walk, he expanded his engagement with his world.

While Mulder was content to slacken his pace at first, not so for Woytowich. His environment seemed to beckon to him and he was challenged by it. He always saw something that he wanted to do. After sitting for a while, he felt rested and was ready to engage in some task:

> I would be sitting there beside the garage and I would think,

> ah hell, I should repair this table or something like that. And I would get up full of ambition, and by the time I get the hammer, and the drill, I would have to sit down. So I wasn't even able to put the stuff away.

Woytowich's attempts to push back his frontiers often ended in failure. His physical capacity was no match for his physical surrounding.

Part of Martin's convalescence was spent at the beach with his mother who was there "to keep an eye" on him. The setting seemed ideal: "It's a nice place; it is right on the beach with a boat and all that," said Martin. But there, away from his usual environment, he became absorbed in himself. He was alone with his thoughts. He tended "to sit in a chair and to wonder" about what he was going to do. In reflecting upon this experience, he felt that it would have been better for him to have spent that time in the Supreme Court Library researching and writing an article on some "esoteric point." There he would have been much more absorbed in the task at hand and much less in himself.

For Hamilton, being at home made him feel like a "sickling" because he could not go to work. Moreover, it was difficult for him to get used to being there. Always being time-conscious and task-oriented, he said, "At work the hours and the minutes go so quickly"; but when he was forced to stay at home he mused, "Everything goes so slowly." He admitted that he could not sit still. He did things he was not supposed to do and then he would "catch heck" from his wife. So at home he, like the other married participants, discovered that his wife monitored what he did and he was chided for noncompliance with the medical regimen.

Experiential characteristic two: Returning home is returning to a previously familiar and managed environment. Now that environment is an obstacle which simultaneously challenges and frustrates the post-MI patient's efforts to engage it.

The tiredness, which at first places limits on what the post-MI patient can do, heightens his awareness of the need to engage in some form of a graduated activity programme which would enhance his stamina and endurance. When he returns home, his daily routine consists of rest, relaxation, and daily walks. Singh began his walking routine in his basement because it was too cold to walk outside. Hamilton, like many post-MI patients, walked in a shopping centre on cold, wintry days.

Regular exercise for all the participants became a way of life. Radowski, Shaw, Woytowich, and Hamilton (after his second heart attack) enrolled in an exercise programme for post-MI patients. Each week they spend a specified amount of time at the gym. Before their heart attacks they had never been involved in an exercise class on a regular basis.

Before joining the exercise class, Hamilton purchased an exercise bike and used it at home. He "tried faithfully" to use it daily, but his good intentions were often preempted by other commitments. He admitted that it was boring. He seemed to think that he had no choice; since he wanted to return to a normal way of life he was prepared to

comply. Strictly speaking, however, "even when there seems to be only one [possibility]," the individual "can always choose for or against that possibility" (Luijpen and Koren, 1969, p. 129). There is always a choice. Sometime later, Hamilton had an opportunity to participate in an individualized exercise programme. He was not enamoured by the routine. "I thought it was nonsense to go down there and pedal a bike. At that time they hooked you up to a monitor." Following the bike routine, he "worked out" on the treadmill. Later he had the option of joining an exercise programme for post-MI patients. There was a willingness on his part to explore new possibilities. He enjoys this programme which combines individual and group activities.

Radowski, Woytowich, and Shaw also enjoy the group classes and the camaraderie. Shaw's positive feelings towards the group surfaced when he said, "I think this is a very valuable thing for anybody who has a cardiovascular problem to be associated with." Woytowich finds the group supportive because:

> it's a feeling you might say of people in the same boat. You know what they have been through.... It's quite a support group. I know some of the guys who started with us quit, but they came back. You can tell they came back because they miss the group. They tried to do this on their own--they find out there are a lot of things you won't do on your own. You have to almost force yourself to do it, and here you do it as a lark.

The coming together in the exercise class builds bridges between the participants. There is a bonding which the post-MI patient finds supportive. It provides the will to do what it is he has to do in order to live life as fully as possible. In the group he is with others who have had a similar experience.

Radowski is more at ease with the exercise group participants than he is with his former co-workers. With the exercise group he can be himself. They partake in the same activities, so he does not stand out because he acts in a different way. For example, at the end of each class they get together in the cafeteria for coffee or juice. When he is with his old friends from his work place, they get together to have "a few beers." Since he limits his beer consumption, the change in his behaviour is obvious. He becomes aware of himself as separate and distinct from his old friends. He can anticipate the response which his presence will evoke.

Experiential characteristic three: Joining an exercise group for the post-MI patient creates new possibilities for living. It enlarges his world.

As the post-MI patient limits, changes, and/or modifies his involvement in the work situation, he has time to develop other interests. Hamilton, who always liked cooking, had time to indulge his predilection during his convalescent period. Moreover it was something to do, so that was when he got started in what has become part of his daily routine. Now he leaves his office in time to have supper ready when his wife returns from work. Radowski, too, enjoys cooking and experiments with various recipes. He also has supper ready by the time his wife and daughter return home in the evening. Both Hamilton and

Radowski situated themselves in their surroundings and responded to what Benswanger (1979) called a "spatial meaning." They engaged their immediate environment in a new way, and this was rooted in an awareness of themselves and their relationship to their surroundings.

Through Singh's involvement with his children's extracurricular activities, he has come to know "a lot" of people in his community. He usually gets "roped into" being the parent representative on the hockey team. He was also on the soccer executive and was a Cub leader. He became more involved in his community. He moved out to explore new perspectives, and like the children Benswanger studied, he "grows in the midst of an existing world he discerns and elaborates" (p. 115). In a way, as the post-MI patient discovers and rediscovers his world, his experience is similar to that of the child. Moreover, surviving the heart attack is like a re-birth, a new beginning.

After his heart attack, Martin was less willing to accommodate and more inclined to deal with issues as he discovered the emotional aspect of his being. In the work place, he was very task-oriented and the feeling aspects were knowingly or unknowingly suppressed. He said, "When I contrast myself now and say before the heart attack, I had great difficulty at the fundamental level understanding myself with the vast majority of people as to what I really thought and felt." Now he is able to get in touch with his feelings and to communicate them in the work situation. "I deal much more directly with that side of myself than I did before the heart attack." He is able to enter the depths of himself which means, as Marcel shows, "fundamentally to get out of oneself, and since there can be . . . no question of our having

two objectively separate selves . . . the return is not identical with what was given before" (Marcel, 1950, p. 132). In other words, in getting in touch the individual is not the same person that he was before the self-examination took place. He emerges as a different person, as Martin testifies.

His environment often presented Mulder with obstacles, but each time he persisted and triumphed. This increased his self-confidence. Each crisis became the occasion for reflection and for finding a more appropriate way. For example, in Madeira he wished to visit a certain place. In order to get to the bus stop, he had a choice of walking about half a mile or taking a more direct ascent by climbing a flight of stairs. He chose the latter; half way up the stairs he thought he would NEVER make it. But he persisted even though he should not have done so. The next day he took a cab. He said, "I felt rather more confident. I had survived it. I think every crisis you survive makes you more confident." He was able to discover within the crisis situation another way of doing; but also in being challenged and in so doing, he confronted rather than avoided difficult situations. He was not afraid to take some risks.

Experiential characteristic four: When the environment is experienced as an obstacle, the post-MI patient may pause to reflect upon the situation; and in so doing, he becomes more in touch with himself and his surroundings and discovers his capabilities or lack thereof.

Shaw was forced to reduce the pace of his hectic work schedule. Recall that his return to his old ways of doing things coincided with another heart attack. By being less involved in the details, he is able to channel all his energies into what he does and to gain greater satisfaction from his more concentrated effort. Now he is able to find ways to do things "more imaginatively and more economically" since he is no longer mired in trivialities. He can see beyond the present--he is able to grasp the Gestalt. Recently, he acted to forestall what could have been a very costly mistake for his company. It may even have meant its eventual demise:

> I knew they were making a definite mistake. . . . They were all for expansion. . . . I am glad I opened my mouth. People who opened all those offices just went broke left, right, and centre. Thank God we didn't.

Living in a More Authentic Way

Living in a more authentic way means constructing a place in which one feels secure and in control, a place in which one is able to realize his potential (Macquarrie, 1973). For the MI patient, this is difficult to achieve in the hospital setting because he seems to lose control of his life. What he does, when, and how--admittedly, it is predicated on his capacity--is usually decided by someone else. He marches to the other's tune. The MI patient, however, still has the option of choosing to accept or refuse the medical regimen. But what does noncompliance achieve? The very act of compliance seems to foster a taking stock and this is germane to living in an authentic way.

since taking stock heightens the individual's awareness of the themes and nuances which characterize his life and how these are related to his landscape. As Benswanger (1979) notes, "We come to understand spatiality by attending to its subtle meanings and permutations. . . . Each of these images suggests a different possibility and evokes a different response from a human subject" (p. 114).

While Mulder was in the hospital he had many visitors, but in the beginning "it was too much" and he just let them talk. He was at once there and yonder. "You get that de-realization, that things are not real. You are just an outsider." At home his experience was similar, as the tiredness lingered on for some time, but being in his own landscape he acted differently. No longer being confined to a few square feet, as he was in the hospital, he could escape. "I just went to my room," he said, "and laid down. That is what I did. I just sent them away. . . . I said, 'I am too tired, you have to go.'" His sense of comfort, familiarity, and security in his own surroundings influenced the way in which he encountered and shaped his world.

Within a matter of hours of being hospitalized, Martin began to research and to develop an exercise programme which he planned to implement on discharge. Finding the written resources on the topic in the hospital inadequate, he had his wife conduct a library search. This was his programme. While his cardiologist was not actively involved in developing the programme, he did not discourage his efforts. Martin's plans were directed towards his world and were geared to enhancing his being-in-the-world.

Martin's most significant change occurred in the work place where

he gave up "courtroom combat" for academe. This took about two to three years to materialize. As he said, "Immediately after my heart attack I was just as obsessive about work as I always was." The change also involved a change in domicile. Martin was fortunate in that his wife was supportive of his plans: "She didn't mind packing up and shoving off to North America, doing all those things we have done and taking all in her stride. . . . She clearly is an enormously supportive person."

Experiential characteristic five: To live authentically, the post-MI patient has to regain control over his interactions with his surroundings.

Hamilton's major preoccupation was his work; his family came second. He had very little time for them because he spent "a lot of time" with his clients when it was not necessary to do so. After his heart attack this changed. He was more involved with his family. Singh, too, by limiting his involvement in his work situation, has been able to spend more ~~time with~~ his family. By choice he shares many activities with them. Father and son jog and play racquetball together. By being authentically with others, Hamilton and Singh are able to be free and responsible (Macquarrie, 1973). To own and to live their commitments to their families, they have taken possession of themselves.

Radowski is doing what he wants to do. Since being unemployed by the company's financial situation, he has not been actively seeking another position. He knows what he would like to do, but his expectations seem unrealistic and he is aware of that. For example, he wants a job without stress. Moreover, his general health status has improved since he has been unemployed--his elevated blood pressure has returned to normal, and he no longer requires medication to achieve this effect.

Home is a safe, peaceful haven for both Mulder and Shaw. Shaw looks forward to going home after a busy day at the office. Moreover, when he was involved in that major project, whenever he felt tired he would go home to recuperate. It was also at home that he did his thinking about the project. Mulder enjoys the solitude of his apartment. The atmosphere is relaxing; there he can be alone with his thoughts, his books, his dreams, and he can enjoy his own company: "In the winter I still enjoy being by myself a lot."

Experiential characteristic six: The post-MI patient lives authentically to the extent that he strives to re-create himself in his own image and that he is not moulded by external factors.

To live authentically, the post-MI patient has to get in touch with himself and his situation. He has to be aware of how he is in the world. Man's existence, Marcel (1950) says, is not something that he "passively suffers but actively lives" (p. 144). In order to achieve

this the post-MI patient has to re-create his world; he has to carve out a niche where he can be himself, where he can realize his dreams and create new possibilities. He is not, however, isolated from his surroundings since he is always in a situation. Being in a situation does not mean he is an "autonomous whole," that he is "self-contained, on the contrary such a being is open. . . . One might even say that such a being is permeable" (p. 145).

CHAPTER 9

REFLECTIONS: POSSIBILITIES FOR PRACTICE AND RESEARCH

Introduction

In this final chapter I propose to address two questions. Firstly, what are the implications for health care practitioners of the insights into and understanding of living with a history of a heart attack that have emerged from this study? Secondly, what are some of the implications of the mode of research exemplified in this study for nursing research generally?

Implications for Health Care Practitioners

This study began with a quest for insights and understanding of the participants' experiences of living with a history of a heart attack. The focus has been on elucidating their experiences for the sake of opening up possibilities for being more helpful to the post-MI patient. The conversations with the seven participants revealed that after a heart attack the body, the other, time, and space are experienced in a different way. It is in terms of the fact that the individuals' awareness of themselves, others, and their surroundings are experienced in a different way that the experiential characteristics

were identified. On the basis of the experiential characteristics, I shall construct composites of the participants' experiences. These composites are organized around the experience of the body, other, time, and space. Following each composite are implications for practice by health care practitioners.

The Body The pain disrupts the MI patient's engagement in the world and forces him to focus on his body, which is experienced as an obstacle. The pain is accompanied by other symptoms, such as excessive fatigue, which persist for some time. The post-MI patient ongoingly encounters his absolute corporeal limits if he fails to respond to his body's needs. Survival and health depend on being attentively attuned to the meaning and significance of each symptom of physical discomfort. Moreover, there is a heightened awareness of bodily discomforts as the body tends to be experienced as a separate entity. The post-MI patient learns to deal with his body in a mechanic-like fashion; and as the body takes meaning as an object, he finds new ways of doing. Furthermore, he may discover the benefits of exercise, as he puts his body through its paces, while being attentive to the body's response.

Implications

- The post-MI patient's adherence to the therapeutic plan may be superseded by noncompliance. As he begins to listen to his body, he may be less inclined to listen to what the health care professionals have to say if what they say conflicts with what he knows. For the health care professional, the impasse should signal, as a minimum

requirement, the need to determine the meaning and the significance of the situation for the individual.

- After a heart attack, the person may develop a preoccupation with his body and its functions. Thus cardiac rehabilitation programmes which focus merely on the physical aspects of recovery may inadvertently reinforce this disposition. There is a possibility that the post-MI patient may become estranged from his body in the long term, if it continually thwarts his projects. Hence there is a need for a holistic approach to cardiac rehabilitation, one which maintains the mind/body unity.

- As the post-MI patient learns to listen to his body, he should be encouraged to share his feelings with the health care professionals. Likewise, the latter should share their knowledge of the clinical aspects with the post-MI patient. This kind of sharing would be facilitated by a dialogical encounter rather than by a didactic approach. There is an integration of personal and professional knowing which should enhance the post-MI patient's capacity to adapt to a new life, which is the ultimate aim of rehabilitation.

The Other The other has the potential for assisting the post-MI patient in re-engaging his world or for distancing him from it. When the other is experienced as being with him rather than merely next to him, there is a coming together. In the coming together he experiences the other as caring. This may become the occasion for discovering "qualities" in the other that he may have been oblivious to before.

(Naturally, the crisis may be the occasion for these attributes to surface.) These attributes in the other may be enabling if they give him a sense of security. The vulnerability that he may feel in the acute stage of the illness can make him more aware that his children need him (that they too are vulnerable), and as he recovers and life returns to normal he may find new ways to live his commitment to them. The heart attack may become the occasion for changing the way he relates to his family as he discovers how tenuous life can be.

Care in the immediate post-heart attack period can count as control, as time goes on, when the post-MI patient's attempts to change the status-quo are met with resistance. Constant surveillance diminishes the post-MI patient as a person. It may wrest control from him. But when his body fails him, the other is the possibility for care or for increased objectification (stare). Furthermore, if his physical limitations persist, these may be experienced as "differences" which separate him from the other. Thus he may be unable to experience sameness, or oneness with his fellow beings.

Implications

- Health care professionals and significant others must aim at a balance between a laissez-faire and an overprotective stance toward the post-MI patient as he regains his health. It is necessary to be sensitive and to recognize his need for help. Moreover, it is not only a matter of knowing when to intervene but how to intervene, since the way of intervening has the potential for enhancing or diminishing the post-MI patient as a person.

- Health care professionals must be alert to manifestations of overprotectiveness by the post-MI patient's family. In addition, professionals need to be sensitive to ways in which they may intentionally or unintentionally foster the family's overprotective stance.

- Care needs to be taken to ensure that the post-MI patient and the family know his limitations and his potentials.

Time . Initially, the past may be appropriated in order to make sense of the event of the heart attack. The past which is recollected, however, is not the past that was lived through; yet it is truly the past so recollected that is significant in the interpretation and experience of the present. The past lives in the present, in so far as the post-MI patient changes the way he lives in order to remedy the errors of the past.

The experience of the heart attack may profoundly affect the individual's sense of life's priorities; his encounter with death may give him a heightened awareness of time and change his outlook on life. Forgetting the event is never total--the memory is a silent partner.

Implications

- Being attentive to the post-MI patient's past enhances the health care professional's capacity to gain insightful understanding into the post-MI patient's experience.

- The heart attack may be a freeing experience. It may set the post-

MI patient free to enjoy and experience what really counts for him.

- The asking of the question "Why me?" could become the occasion for coming to terms with the event, and for channelling the post-MI patient's energies in a constructive way.

Space In the hospital, feelings of loss of control may negate the positive effects of feeling secure and create ambivalence for the MI patient. Going home is returning to a previously familiar and managed environment. Now that environment is an obstacle, as it simultaneously challenges and frustrates his efforts to engage it. When the environment is experienced as an obstacle, he may reflect upon the situation and in so doing he becomes more in touch with himself and his surroundings and discovers his capabilities or lack thereof.

As the post-MI patient regains his health, he may enroll in a cardiac exercise program, which creates new possibilities for living. It enlarges his world. But to live authentically, the post-MI patient has to regain control over his interactions with his environment. The post-MI patient lives authentically to the extent that he re-creates himself in his own image and that he is not moulded by external forces. He is able to create a place for himself.

Implications

- The health care professional needs to be able to differentiate between the relinquishing of control and the loss of control that the post-MI patient may experience. On the one hand, the MI-patient may choose to relinquish control over certain aspects of his life during

the acute and convalescent phases of his illness. On the other hand, he may be forced to relinquish control and this may be experienced as a loss of control. In an unfamiliar setting, such as in the CCU, the patient may be more inclined to relinquish control. In a familiar setting, however, such as the home, being forced to relinquish control may be experienced as a loss of control. Feelings of loss of control may surface in a number of ways: for example, at one extreme there may be noncompliance with the therapeutic regimen; at the other extreme, feelings of loss of control may express themselves in passivity.

Reflections on the Mode of Research and Its Place in Nursing Research

In this research the focus has been on the lived experiences of persons who live with a history of a heart attack. After having carried out the research, I now offer some reflections about the approach I used and why I regard it as an approach that is particularly suited to researching the lived experience. After I have done this I shall consider the kind of knowledge yielded by it, and place this in the context of fundamental patterns of knowing in nursing which Carper (1978) has identified.

The Mode of Research in this Study

As researcher, I entered into a dialogue with each participant. The talk was about the individual in his world. I listened, reflected, and shared my insights. Without a questionnaire to constrain the talk

and to distance me from the participants, the conversations flowed freely. Our talks, however, were not without a focus. We were oriented to the question of what it is like to live with a history of a heart attack. Our talks were about sustaining a heart attack and life after the event. I tape-recorded the conversations in order not to be distracted by note-taking, on my part, and in order to be able to give my full attention to the encounter.

Together we explored the question of this study as fully as possible. As the participants related their stories, they began to reflect on their experiences as they searched for examples to clarify a point. In reflecting, they also gleaned insights which they shared with me.

The give and take of the dialogic process produced insights which could not have emerged within a more structured approach. The dialogue permitted me to explore more fully the individual's situation. I could attend to peculiarities of the situation at hand. It allowed me to approach each person as an unique individual. Questions, when appropriate, were phrased in terms of the individual's experience, unlike a formal research questionnaire where the phrasing of the question is uniform for each person. I believe in this way I was able to glean insights and to "see" what another approach might see less clearly. In addition, by gaining a view of the individual in his world, I was able to gather the conversational fragments into a whole (illustrated by the narratives), fragments that would tend to remain isolated in other studies.

What is it like to live with a history of a heart attack? This is the question which guided my inquiry. Phrased in this way it is a

question about lived experience, something that the person has lived through, or for the purpose of this inquiry, something the person continues to live through as the experience continues to unfold.

Gadamer's (1960/1984) thoughts on the asking of the question focuses our attention on what is taken-for-granted when we ask a question:

> It is the essence of the question to have sense. Now sense involves direction. Hence the sense of the question is the direction in which alone the answer can be given if it is to be meaningful. A question places that which is questioned within a particular perspective. . . . In order to be able to ask one must want to know. (p. 326)

Being able to elucidate the patient/client's experience is integral to nursing if the goal of nursing is to provide individualized care. But the question remains, how do we appropriate the other's experience? I struggled with this question throughout my investigation, and for me it remains a question that is complex.

There is a tendency for informants (in the research situation) and patients/clients (in the practice setting) to recall facts. Although their stories may be rich in factual details, they fail to elaborate the lived experience. For example, "It was about 8:15 a.m. I was on my way to work when I felt this pain in my chest. When I arrived at work it got worse; I felt sick to my stomach. My boss persuaded me to go to the hospital. In fact he took me in his car." Or "I was very depressed during the first year." What is it like to be depressed after a heart attack? Words seem to fail the respondent, and yet it is largely through words that we are able to access the other's experience. The tendency is to say, "That's too hard to explain". And

further attempts to explore the situation may be met by resistance. Thus labels like "depression" or "anxiety" tend to conceal rather than to elucidate the experience.

In order to explicate the experience, I had focused conversations with the participants. This yielded a vast amount of material. I limited the number of participants for two reasons: (1) fewer participants meant a more manageable amount of material, and (2) I was able to stay as close as possible to firsthand reports in developing the text of this thesis.

This study has opened up, for me, the question of how we research the lived experience (especially in a situation which unfolds over time as opposed to the investigation of a specific moment in the life of an individual), and it represents a beginning in my quest. This research endeavour has raised a second related question. As the stories unfolded it became apparent that the significant other, more specifically the spouse, plays a major role in how the post-MI patient experiences his world. It would seem reasonable to devote future research to understanding the spouse's experience--what it would mean to be the wife of someone who has had a heart attack.

What insights, relevant to me as a nurse, have been gleaned from this study?

(i) Noncompliance with the medical regimen may not be due to a lack of motivation or to denial, but could be the consequence of conflicting messages. As the post-MI patient learns to listen to his body and to interpret what it is saying, the body's message may be in conflict with what the health care practitioner prescribes. In time he

may come to trust and be guided by what his body has to say. In other words, he may come to trust his knowing.

(ii) While other studies have identified the family's overprotective stance as an issue, this study has shown how the individual experiences overprotectiveness and the ways in which overprotectiveness has the potential for limiting the post-MI patient's possibilities.

(iii) It appears that the post-MI patient has to come to terms with the question, "Why me?" in order to go on living. To ask the question, "Why me?" is to return to the past so as to make sense of the event and to plan for the future. It becomes the occasion to grow in self-understanding.

(iv) Feelings of being in control are, in part, related to how the post-MI patient experiences space. It may be easier to relinquish control in an unfamiliar place than in a familiar one. In addition, if the post-MI patient is to be enabled to take responsibilty for his own choosing, the milieu must be structured to expedite the process.

Limitations

Seven post-MI patients cannot be considered to be representative of the general population of persons who live with a history of a heart attack, so it is not possible or even the intention of this study to generalize the "findings."

The purpose of this study is not to generate predictive statements but to shed light on the meaning of sustaining and living with a history of a heart attack. To what extent was the purpose achieved? I have attempted to elucidate the participants' experiences through des-

cription and interpretation and to capture the focal points in the experiential characteristics. When the experiential characteristics are isolated and taken out of context, they become simplifications and may appear to reveal similarities to other conditions and illnesses. The experiential characteristics have to be understood in the context of the whole in which the meaning emerges. It is this context that gives meaning to the experience.

Six of the narratives of the seven men, whose post-MI experiences are described in this investigation, are stories about persons who returned to a normal way of life. Woytowich's story, which focuses on his pre-bypass experience, is the exception. His story is about an individual who sustained severe damage to his heart tissue which resulted in extensive residual disability. (This was later remedied by surgery.) But there are other stories which did not surface in this study, such as the stories of persons who become cardiac cripples, persons who function at a level below which they are physically capable of performing (Monteiro, 1979). By and large, then, these descriptions and experiential characteristics relate to one type of story, the story about returning to a normal way of life.

Fundamental Patterns of Knowing in Nursing

The experiential characteristics are meant to provide insightful understanding into the experience of living with a heart attack. According to Gadamer (1960/1984), however:

> understanding is always interpretation, and hence interpretation is the explicit form of understanding. . . . Understand-

> ing always involves something like the application of the text to be understood to the present situation of interpretation. (p. 274)

Understanding, interpretation, and application comprise "one unified process" (p. 275). An awareness of the experiential characteristics opens up possibilities for health care professionals to be of service to post-MI patients. The experiential characteristics speak to one of the four fundamental patterns of knowing in nursing which Carper (1978) has identified, namely to esthetics: the art of nursing. The other three patterns she has distinguished are empirics, the science of nursing; the component of a personal knowledge in nursing; and ethics, the component of moral knowledge in nursing (p. 14).

Carper points out:

> Each pattern may be conceived as necessary for achieving mastery in the discipline, but none of them alone can be considered sufficient.... Nursing depends on scientific knowledge of human behaviour in health and illness, the esthetic perception of significant human experience, a personal understanding of unique individuality of the self and the capacity to make choices within situations involving particular moral judgements. (p. 22)

According to Carper, nursing research has focused mainly on the empirics. The esthetic pattern of knowing in nursing has not been elaborated and made explicit in the same way except "to vaguely associate the art of nursing with the manual and technical skills which are involved in nursing" (p. 16). The esthetic pattern of knowing is more amenable to a human science approach than the traditional scientific method. The latter has been developed to explain specific phenomena rather than to promote understanding of the meaning that the experience has for the participants.

Wiedenbach (1964) claims that:

> the art of nursing is a helping process with action directed toward providing something the patient requires or desires and which will restore or extend the patient's ability to cope with demands implicit in his situation. . . . Art is individualized action. (p. 36)

But according to Carper (1978), "The action taken to have an esthetic quality requires the active transformation of the patient's behaviour into a perception of what is significant in it--that is what need is being expressed by it" (p. 17). It is perception which gives the action its esthetic quality. Carper invokes Dewey's differentiation between mere recognition and perception--recognition being equated with identification and perception with "a gathering together of details and scattered particulars into an experienced whole for the purpose of seeing what is there" (p. 17).

The art of nursing necessitates seeing the patient as a particular person and goes beyond the diagnostic label, the label of "MI patient." The nurse must see the patient as a particular person situated in time, in a particular place, and interacting with others (Gulino, 1982). This speaks to a holistic view of the person, and it is through reflection that the nurse "attempts to mine the total presence" (p. 356) so as to uncover the meaning of the situation that is of relevance to her. This meaning, Benner (1985) states, resides neither solely within the individual nor within the situation "but in the transaction between the two, so that the individual both constitutes and is constituted by the situation" (p. 7).

Orem (1985) continues the esthetic theme when she emphasizes that the primary focus of the art of nursing is the "creative designing" and "creative production of care" (p. 5). The notions of art as indivi-

dualized action (Wiedenbach, 1964) and as a creative approach (Orem, 1985) are rooted in thoughtfulness. And "it is from the auspices of thoughtfulness", van Manen (1984) states, that we can act "with tact and tactfulness" (p. 11). Our ability to act with thoughtfulness is grounded in "being sensitive to the uniqueness of a particular person in a particular situation" (van Manen, p. 5). Thus it points to the need to elucidate the person's experience of the situation. In other words, an approach is needed which illuminates the human experience as it is lived, an approach that yields insights and understanding and which is necessary if nursing as art is to achieve its goal of personalized care.

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APPENDIX A

INFORMED CONSENT FORM

THE UNIVERSITY OF ALBERTA
DEPARTMENT OF SECONDARY EDUCATION - CURRICULUM AND INSTRUCTION

INFORMED CONSENT FORM

TITLE: Lifeworld Study of the Myocardial Infarction Patient

INVESTIGATOR: Joan S. Ford, RN, BN, MSc (Applied)
PROVISIONAL CANDIDATE, Faculty of Graduate Studies and Research, Department of Secondary Education - Curriculum and Instruction
The University of Alberta
Tel: 432-7103 (Residence)

ADVISOR: Dr. Max van Manen, BEd, MEd, Ph.D.
Professor of Secondary Education

PURPOSE OF THE STUDY:

The purpose of the study is to come to a systematic understanding of the lived experience of persons who have had a heart attack (myocardial infarction); to go beneath the surface structures in order to describe patterns and to penetrate the deeper meaning structures of the event. It is a search for the nature or meaning of the experience.

PROCEDURE:

Participants will be asked to tell about their experiences, what life is like after an MI. Each interview will last approximately one to one-and-a-half hours, and will be tape-recorded. I anticipate two or three sessions with each participant. The names of the participants will not be disclosed at any time. To ensure anonymity of participants, fictitious names will be used in my dissertation and in any articles or reports.

Although participants in this project may not benefit directly from this study, it is anticipated that in telling their stories and reflecting upon their experiences that they may gain new insights regarding their situation.

This is to certify that I, _____, HEREBY agree to participate as a volunteer in the above project.

I CONSENT to two or three one to one-and-a-half-hour long interviews, and for these interviews to be tape-recorded.

I UNDERSTAND that my identity will not be disclosed.

I FURTHER UNDERSTAND that I am free to withdraw my consent and terminate my participation at any time without penalty.

I have been given the opportunity to ask whatever questions I desire and all such questions have been answered to my satisfaction.

_____ _____

Signature Date

_____

Witness

APPENDIX B

INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

Hamilton	February 20, 1985
	February 27, 1985
Martin	January 15, 1985
	January 25, 1985
Mulder	June 21, 1984
	June 26, 1984
Radowski	January 30, 1985
	February 9, 1985
Shaw	December 15, 1984
Singh	February 5, 1985
	February 12, 1985
Woytowich	January 16, 1985
	January 23, 1985

APPENDIX C

QUESTIONS FOR GUIDING THE CONVERSATIONS

EXAMPLES OF QUESTIONS FOR GUIDING THE CONVERSATIONS

What was it like for you when the doctor said that you had a heart attack?

What was the hospital experience like?

What sustained you during that time?

What was it like to go home?

Did you make any lifestyle changes after you heart attack? (Changes in smoking, diet, and exercise behaviour, and stress management practices.) How were these experienced?

How was it to return to work?

How, when and in what way do you think about your heart attack?

What feelings does this elicit?

How often do you have a check-up? What is it like having a check-up?

In what ways has having a heart attack affected the way you live today?

What is it like to live with the fact that you have had a heart attack?

Has having a heart attack changed the priorities in your life?

What is important to you?

Has having a heart attack changed the way in which you relate to your family, and friends? Give examples.